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Breaking News for Michigan Doctors

MICHIGAN MEDICINE

Vol. 79, No. 1
January 11, 1980

MEDIGRAM

CAPSULES

NEARLY 2,500 COPIES of the new 1980 MSMS Roster of Members will be mailed late this month to physicians and others who ordered them in November. MSMS members who did not place orders with the forms printed in the November issues of Medigram may contact Lenora Evey at MSMS headquarters. The rosters contain both county and alphabetical listings of MSMS members, as well as addresses and telephone numbers of key health agencies in Michigan, and lists of MSMS officers, councilors, staff and staff functions.

EDITOR'S NOTE: The February issue of Michigan Medicine will not carry the detailed series of articles on the bed reduction issue promised in the Dec. 21 Medigram. Instead, those articles will appear in the March issue of the MSMS journal. Please continue to read Medigram to keep posted on developments.

In this issue . . .

Important medical bills pending action in this legislative session are described by the insert inside this issue. The MSMS Department of Government Relations, which prepares a semi-annual list for Michigan Medicine/Medigram, also has included the current MSMS position on some of the bills.

Legislature's 1980 concerns include key medical bills

The state legislature reconvened Wednesday, Jan. 9, concerned with a flock of legislation due for final action in 1980 and with election of House members coming up next fall. Highest among health legislation this year will be the House-passed HB4555, designed to reform Blue Cross Blue Shield of Michigan and put in place efforts to contain health and medical care costs. Other new health legislation includes SB778, to make psychologists and other allied health professionals eligible for direct BCBSM reimbursement; SB881, to separate osteopathic facilities from allopathic facilities in certificate of need legislation; and looming appropriations bills affecting medical programs and medical education in one of Michigan's worst fiscal years. New legislation probably will be introduced to provide for disposal of radioactive waste by hospitals and to resolve the matter of physician-owned self-referral laboratories.

Also to be settled will be the fate of two appointments closely related to medicine. Richard Hemmings, once rejected as insurance commissioner, has been renominated by Governor Milliken. Action on that appointment is due before March. Samuel Gershon, MD, Department of Mental Health choice for director of schizophrenia research center Lafayette Clinic, may require special legislation regarding his selection.

June 2 trial date set in FTC complaint against MSMS

Pre-trial work continues by both sides in the matter of the Federal Trade Commission complaint against MSMS. The FTC alleges illegal activities by MSMS in regards to Blue Cross Blue Shield of Michigan. MSMS legal counsel is completing its search of approximately 200,000 documents at the FTC's Washington DC offices. The FTC has until Jan. 15 to indicate which individuals it wishes to take depositions from. The trial date has been set for Monday, June 2, with the location yet to be determined.

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THERE ARE MOVES to decrease federal support of medical education and put greater responsibility on state funding. That was one of the major ideas to come out of the AMA's sixth annual State Health Legislation meeting in Phoenix, Jan. 3-4. Attending the meeting from MSMS were President Ernest P. Griffin, Jr., MD; President-elect John R. Ylvisaker, MD; Medicaid Liaison Committee Chairman David Siegel, MD, and Bruce Ambrose and Sherry Wellman of the MSMS staff. The meeting also emphasized continued legislative concentration on health care cost containment.

A RECENT SURVEY conducted by the Area Agencies on Aging among 13,000 Michigan senior citizens indicates the cost of eyeglasses is the number one concern of the elderly. Second is the cost of dentures, followed by the costs of funerals, medications, home heat and energy. The gap between doctors' fees and Medicare payment levels is eighth, while the inadequacy of Medicare ranks 13th in the list of 19 items. Medicaid misuse by providers ranks 14th.

MSMS analyzing MDs' comments and HSA bed reduction plans

MSMS HSA/Physician Support Center staff is analyzing the bed reduction plans submitted by six of the state's health systems agencies to the Statewide Health Coordinating Council. The other two of the state's eight HSAs did not have excess hospital beds, according to the state's calculations. The MSMS Physician/HSA Support Center, headed by Dennis Paradis, has been collecting statements from physicians as to how they think proposed bed reductions will affect medical practice in their home areas. Physicians' comments have been requested by the MSMS Council, which will receive the Support Center's report and recommendations Jan. 23.

The six affected HSAs all submitted their bed reduction plans to the SHCC by the Dec. 21 deadline. The SHCC Ad Hoc Committee on Bed Reduction has recommended the plans of the HSAs based in Flint and Detroit be returned for more specifics. The Comprehensive Health Planning Commission of Southeast Michigan (CHPC-SEM) submitted its plan without any mention of Martin Place Hospital, which obtained an injunction restricting any mention of its beds. All other southeast Michigan hospitals were named in that report.

Oakland University again offers Medical Review Program

Physicians anticipating taking the Federal Licensing Exam (FLEX), the exams of the Educational Commission for Foreign Medical Graduates (ECFMG), and/or the Visa Qualifying Exam (VQE), have an excellent opportunity for educational review in a program to be presented spring term at Oakland University. The OU Medical Review Program provides an intensive 12-week review of the basic sciences, clinical sciences and patient management problems. Students are registered as full-time graduate students and receive 16 academic credits upon successful course completion. Further information is available from the Medical Review Program, Center for Health Sciences, Oakland University, Rochester, 48063. (313/377-3563). The medical review program now is self-sufficient, but was supported in its beginning by MSMS. Tentative plans are to continue to offer the program twice a year, with starting dates in early March and September.

HOUSE OF REPRESENTATIVES

Proposed Legislation

1979

- HB 4002 Amendments to the Anatomical Gift Act - Removal of Corneas
Sponsor: Representative Lucille Mc Collough
This bill establishes a procedure by which a county medical examiner may authorize removal of corneas for transplantation and research purposes, in medical examiner autopsies, without express refusal of next of kin. Amendments to include pituitary glands and middle ears were rejected.
Status: Signed by the Governor, PA 42 of 1979
MSMS Position: Support
- HB 4050 Sunset Evaluation Act
Sponsor: Representative Forbes, Hollister, Wilson, et al.
This bill would establish a joint sunset review committee of the legislature to evaluate state bureaus, boards, commissions, committees, councils, departments and divisions, the evaluate the feasibility of their continued activity.
Status: Committee on House Policy
- HB 4078 Legalization of Laetrile
Sponsor: Representatives Kelsey, Trim, Bennett, et al.
This legislation legalizes the manufacture, prescribing or administration of laetrile. The bill relieves the physician of liability or disciplinary action by the Michigan Board of Medicine if the patient's condition continues to deteriorate.
Status: The bill passed the House and was referred to the Senate Health and Social Services Committee, where it has been stalled. No action is anticipated.
MSMS Position: Oppose
- HB 4085 Michigan Health Service Corps
Sponsor: Representatives Kennedy, R. Hood, Nash, et al.
This bill has been introduced in an effort to facilitate the retention of health care providers in health resource shortage areas. The proposed legislation establishes a loan program for matriculating students. Upon graduation, a forgiveness of the loan will be granted if the student provides health care in a shortage area for a specified period of time.
Status: Reported by House Public Health Committee - Referred to House Appropriations.
MSMS Position: Support
- HB 4187 Department of Social Services Appropriations (Medicaid)
SB 716 Sponsor: Representatives Jowett and Ostling
This is the 1979-80 appropriations bill of over \$2 billion for the Department of Social Services, including physician reimbursement under the Medicaid program for fiscal year ending 9/30/80. It represents a shortfall in the physician line item of approximately \$7,000,000 which will require a supplemental appropriation. Similar legislation must be enacted in 1980 for the 1981 fiscal year.
Status: Signed by the Governor, PA 110 of 1979
MSMS Position: Opposed in form enacted

- HB 4349 Cardio-Pulmonary Resuscitation Education
Sponsor: Representatives Bullard, M. Brown, J. Young, et al.
This bill would require cardio-pulmonary resuscitation training as part of secondary school physical education curriculum.
Status: House Committee on Appropriations with substitute
- HB 4436 Second Opinion on Surgical Procedures
Sponsor: Representatives Bennett and Kelsey
This legislation requires patients to supply a surgeon with a written opinion from another surgeon on the necessity of surgery before a major surgical procedure is performed.
Status: House Public Health Committee
MSMS Position: Oppose
- HB 4555 Blue Cross Blue Shield of Michigan Restructuring
Sponsor: Representatives Hollister and Ryan
This bill is the culmination of months of compromise and controversy in reorganizing BC/BSM. The bill addresses three major areas of concern: Board reorganization, regulation, cost containment and internal operations. The size of the Board is reduced from 47 to 33 members with providers having approximately 25% representation. This piece of legislation is specific in regulation and guidelines for cost containment. The bill allows Blue Cross/Blue Shield and each provider group to develop a provider plan. The provider plan must establish quantifiable and achievable cost, access and quality goals. The corporation is given two years to achieve goals. After two years, the Insurance Commissioner will review the plan. If the goals are met, the state will play no role and there will be no regulation of BC/BSM. The plan remains unchanged for two additional years. If the Insurance Commissioner decides the goals have not been met - without good cause - the corporation may draft a new plan or resubmit the old plan; the Insurance Commissioner also develops a plan. A three member Appeal Board (one appointed by the Statewide Health Coordinating Council, one appointed by the SHAC and one appointed by the Commissioner also develops a plan, and determines which plan will prevail or the Appeal Board may combine portions of the plans with the consent of the parties. The plans may be appealed to the Appellate Court.
Status: Passed House - Referred to Senate Commerce Committee
MSMS Position: Support
- HB 4586 Extension of Brown/McNeely Fund
Sponsor: Representatives McNeely, Maynard, Sietsema, et al.
This legislation would extend the expiration date of the Brown/McNeely Fund until July 1, 1980.
Status: Signed by the Governor, PA 40 of 1979 (6/22/79)
MSMS Position: Support
- HB 4648 Determination of Death Act
Sponsor: Representatives Symons and R. Hood
This bill defines that a person is considered dead, if in the opinion of the attending physician, there is irreversible cessation of spontaneous respiratory and circulatory functions. It further requires that a person must be declared dead before artificial life support functions are terminated.
Status: Signed by the Governor, PA 124 of 1979

- HB 4913 Ethics and Standards - Release of Information (Amends PA 119 of 1975)
Sponsor: Representative Ray Hood
This bill would provide for the release of information relating to ethics and standards of health care professionals.
Status: Passed the House - referred to Senate Health and Social Services Committee
- HB 5224 Transfer of Health Care Facilities
Sponsor: Representatives Owen, Bryant, Ryan
This bill would provide for the transfer of the Wayne State University Clinic Building and Detroit Receiving Hospital to the Detroit Medical Center Corporation.
Status: To the third reading in the Senate

SENATE

Proposed Legislation

1979

- SB 7 Reciprocity for Canadian Physicians
Sponsor: Senator Bishop
This bill would provide for licensure of Canadian physicians by reciprocity if the physician had successfully passed the Licentiate Medical Council of Canada Exam (LMCCE).
Status: Senate Committee on State and Veteran's Affairs
MSMS Position: Oppose
- SB 185 Controlled Substances Therapeutic Research Program
Sponsor: Senators Monsma, et al.
This legislation would establish a Controlled Substance Therapeutic Research Program. This program would conduct research using marijuana to treat patients suffering with a life or sense threatening situation due to glaucoma or cancer chemotherapy treatments. Patients would have to be physician certified and then approved by a three-member patient qualification review board. Twenty statewide pharmacists will be designated for distribution to patients in the program.
Status: Signed by the Governor, PA 125 of 1979
- SB 372 Critical Health Problems Education Program
Sponsor: Senators Faxon, et al.
This legislation proposes mandating local school districts to implement a comprehensive health education curriculum, including communicable and chronic disease education for elementary and secondary schools by July 1, 1981.
Status: Senate Education Committee

- SB 374 Repeal of Drug Control License
Sponsor: Senators De Grow and Geake
This legislation would repeal Section 17745 of the Public Health Code which requires physicians who routinely dispense drugs from their offices to obtain a Drug Control License.
Status: Senate Health and Social Services Committee
MSMS Position: Support
- SB 497 Unprofessional Conduct
498 Sponsor: Senator Corbin
This bill proposes to make it unprofessional conduct for a licensee to promote for personal gain the use of an unnecessary drug, device, service or to require a patient to secure same from a place of business which the licensee has a, "material financial interest." (SB 498 defines material financial interest to mean ownership of more than 5%.)
Status: Committee on Health and Social Services
- SB 633 Increase Number of Osteopathic Medicine and Surgery Board Members
Sponsor: Senator Vaughn
This bill would increase the size of the Osteopathic Board from the current eight members to fourteen.
Status: Senate Committee on State and Veteran's Affairs
MSMS Position: Support
- SB 778 Psychologists, Optometrists, Pharmacists, BC/BSM Participants
Sponsor: Senators Ross, Corbin, Geake
This bill would mandate that a medical care corporation (BC/BSM) would have to allow psychologists, optometrists and pharmacists to become participants.
Status: Passed Senate
- SB 863 Transfer of Health Care Facilities (Refer to HB 5224)
Sponsor: Senator Huffman
Status: Senate Appropriations Committee

Maternal Health Conference registrations now being made

Physicians may register now for the 1980 Michigan Conference on Maternal and Perinatal Health. Complete details of the two-day conference March 5-6 at the Hyatt Regency Dearborn, and a registration form appear in the January issue of Michigan Medicine. The conference annually attracts over 1,000 physicians, nurses and other health care professionals. Major topics this year will be adolescent pregnancies; infections in newborn and mother; ultrasonography, sensors and monitors, and anesthesiology. Further details are available from Katie Brewbaker at MSMS headquarters, 517/337-1351.

February Michigan Medicine to spotlight MDPAC, AMPAC

Physicians' political activities are particularly important in 1980, with the presidential election looming and the national census creating new demographic alignments. The February issue of Michigan Medicine will bring MSMS members an analysis of the major political trends underway, with detailed descriptions of how the Michigan Doctors and American Medical Political Action Committees are gearing up for this critical year. The special series of articles on politics, MDPAC and AMPAC coincides with a major MDPAC membership drive now underway. MDPAC members' dues will support candidates sympathetic to the objectives of organized medicine prior to the November elections.

Public hearing Jan. 30 on state licensing exam rules

Concerned Michigan physicians may present their views on state licensure examination rules at a public hearing scheduled at 2 p.m., Jan. 30 in Conference Room A, 905 Southland, Lansing. The Department of Licensing and Regulation is conducting the hearing. MSMS plans to participate. MSMS also has learned the Board of Medicine will express its concern that the rules remain the same despite some current pressures to allow physicians to take sections of the licensure exam at different sittings, rather than all at once as presently required.

CAPSULES/continued

THE 1980 MSMS CONFERENCE on the Medical Aspects of Organized Athletics is taking shape. The conference is scheduled April 10 at Long's Convention Center, Lansing. Final plans are being made by the MSMS Committee on Sports Medicine, chaired by Charles R. Zimont, MD, Constantine. Program information and a registration form will appear in a coming issue of Michigan Medicine. Details are available from Mert Scholten, MSMS headquarters, 517/337-1351.

EVERY MICHIGAN HOSPITAL should either initiate or revitalize a risk management committee, urges MSMS President Ernest P. Griffin, Jr., MD, in his January Michigan Medicine column. "Hospital equipment and procedures should be evaluated by knowledgeable physicians," he continues. "Such actions may save you time, reputation and money. Most importantly, you may save a patient's life or prevent irreparable damage."

HAVE YOU NOTICED the new masthead on this Medigram? It is part of a 1980 facelift for Michigan Medicine, carried out with the help of Lansing artist and designer Martin Hudson. More design changes, including a new logo, are apparent in the January issue of the journal. The journal also has a new arrangement of features, to align it more with the news magazine format. The Publications Committee and editor hope the changes will enhance the value and readability of the magazine for MSMS members.

CAPSULES/continued

MSMS LEADERS WILL MEET with state Professional Standards Review Organization (PSRO) leaders Jan. 30 in East Lansing. The two groups will evaluate MSMS relationships with PSROs. Representing MSMS will be President Ernest P. Griffin, Jr., MD; President-elect John R. Ylvisaker, MD; Immediate Past President Louis E. Heideman, MD, and Council Chairman Louis R. Zako, MD.

MSMS AND THE AMA DEPARTMENT of Negotiations are co-sponsoring a seminar entitled "Negotiating: A Leadership Skill," Feb. 16-17 at the Lansing Hilton Inn. The by-invitation-only seminar will help 35 MSMS and component society leaders, as well as MDs keenly involved in health planning, to enhance their leadership abilities by developing improved negotiations skills.

Donald Kuiper, MD, Lansing heads new Board of Medicine

A reorganized Michigan Board of Medicine, including a new president, is at work this month. Donald H. Kuiper, MD, Lansing, former board member, is the new president, succeeding John R. Wilson, MD, Grand Rapids, who served the maximum time allowed on the board. New vice president is James C. Breneman, MD, Galesburg, while Margaret Thoms, Birmingham, continues as secretary.

Governor Milliken Jan. 4 named two new MDs and one new public member to the board and reappointed four other members. Newly appointed are Norman Rotter, MD, Huntington Woods, filling Doctor Wilson's position; Sondra C. Shaw, Traverse City, succeeding Arthur Majewski; and Edward R. Weddon, MD, Stockbridge, succeeding Alma George, MD, Detroit. Reappointed to the board were Doctor Breneman; James Dresbach, Taylor; Doctor Kuiper and Carol E. Pearson, MD, Oak Park.

MSMS comments on SHP II

The MSMS Steering Committee on Health Planning is submitting comments on the second State Health Plan (SHP II) to the Planning Development Committee of the Statewide Health Coordinating Council (SHCC). The Plan is required by federal law to serve as a guide for all health planning in Michigan during 1980-84. The MSMS Committee, chaired by Kenneth J. Ray, MD, Trenton, has prepared its comments from the responses of specialty societies on health planning issues that are close to those societies. The SHCC is expected to take action on the SHP by April.

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Editor: Judith Marr

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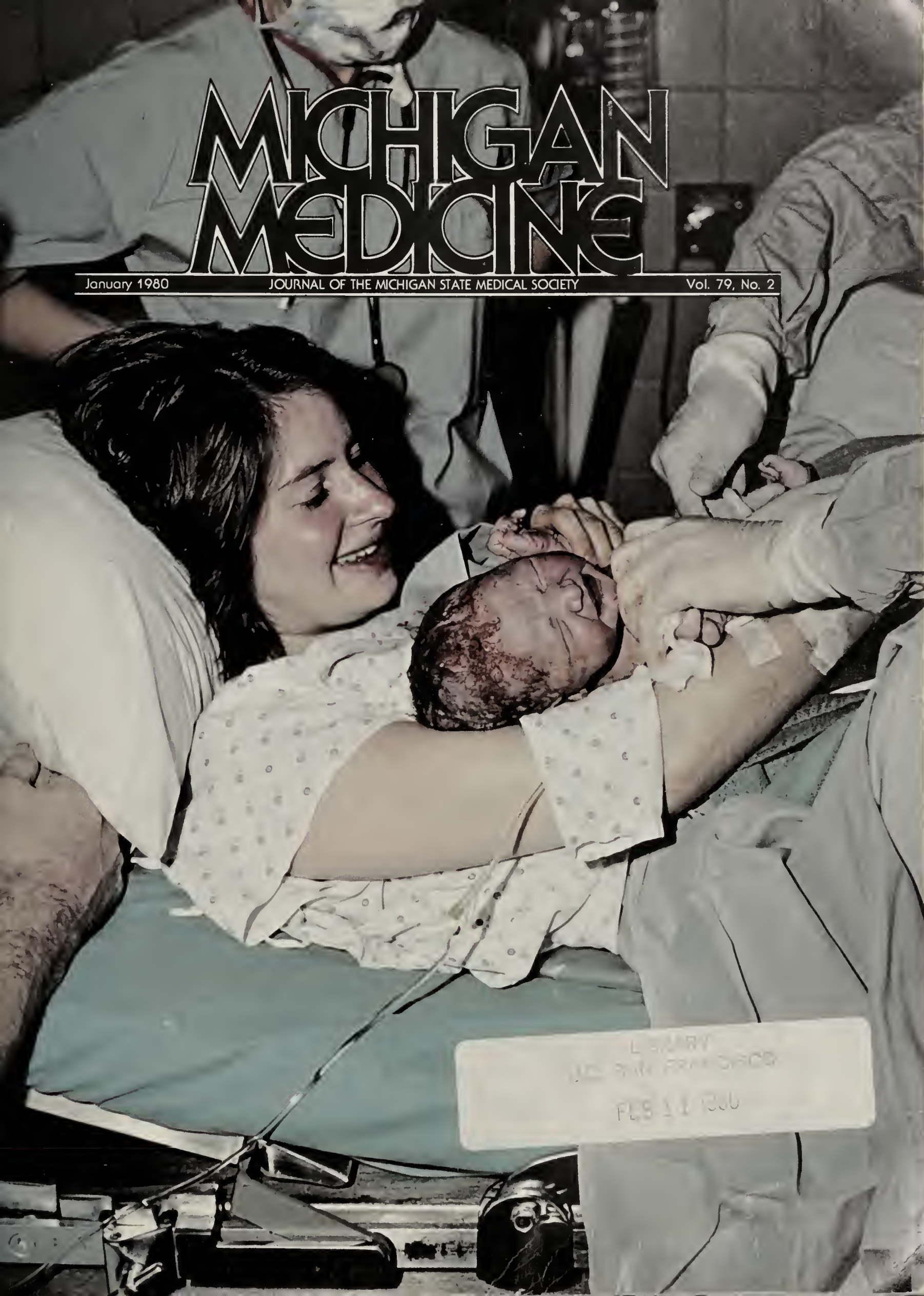
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MICHIGAN MEDICINE

January 1980

JOURNAL OF THE MICHIGAN STATE MEDICAL SOCIETY

Vol. 79, No. 2



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Valium (diazepam/Roche)
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But the individual character of Valium is even more apparent clinically than pharmacokinetically. And far more significant. That's because of the patient response obtained with Valium. A response which brings a calmer frame of mind. A response which has a pronounced effect on the somatic symptoms of anxiety, particularly muscular tension. A response which helps the patient feel more like himself again because of the way Valium reduces the overwhelming symptoms of anxiety and psychic tension.

Another important aspect of the clinical character of Valium is safety. Though drowsiness, ataxia and fatigue are possible, these and more serious side effects are rarely a problem. Of course, as with all CNS-acting drugs, patients taking Valium should be cautioned against driving, operating dangerous machinery or the simultaneous ingestion of alcohol.

Unquestionably, many psychotherapeutic agents, including other benzodiazepines, have antianxiety effects. But one fact remains: you get a certain kind of patient response with Valium. It's a response you want. A response you know. A response you trust as part of your overall management of anxiety and psychic tension.

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Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology; spasticity caused by upper motor neuron disorders; athetosis; stiff-man syndrome; convulsive disorders (not for sole therapy).

The effectiveness of Valium (diazepam/Roche) in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

Use in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

Dosage: Individualize for maximum beneficial effect. *Adults:* Tension, anxiety and psychoneurotic states, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. *Geriatric or debilitated patients:* 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) *Children:* 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

Supplied: Valium® (diazepam) Tablets, 2 mg, 5 mg and 10 mg—bottles of 100 and 500; Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10; Prescription Paks of 50, available singly and in trays of 10.



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A successful delivery each time is the goal of the annual Michigan Conference on Maternal and Perinatal Health, planned March 5-6 at the Hyatt Regency Dearborn. Full details and registration form appear in this month's special section, beginning on page 7.

(Photo by Mert Scholten of Mrs. Richard Warren, Lansing, and her new baby, Trevor William.)

MICHIGAN MEDICINE

January 1980, Volume 79, Number 2

Special Section

- 7 MSMS members may register now for the 1980 Michigan Conference on Maternal and Perinatal Health. Scheduled March 5-6 at the Hyatt Regency Dearborn, this major statewide medical event again will discuss topics of key importance to mother and newborn child. See full details and registration form in this issue's special report, pages 7-10.

Features

- 11 Doctor Shekerjian, new medical director of Blue Cross/Blue Shield of Michigan; Shelton Reece
- 14 New programs underway with MSMS Physician Service Group; Judith Marr
- 16 Area sports medicine conferences; Vern Norris
- 25 Michigan malpractice claims statistics, 1974 to date; John Richards
- 36 Michigan Department of Public Health, part two of a series; Dennis Paradis and Sherry Wellman
- 38 Profile of Lt. Gov. James Brickley; Willah Weddon

Departments

- 2 Editorial; James H. Tisdell, MD
- 4 Letters
- 18 MPMLC Clipsheet
- 20 Meetings
- 30 Health Planning update
- 32 Category I courses
- 34 Ad index
- 42 Classified advertising
- 44 President's page; Ernest P. Griffin, Jr., MD

Our appreciation to artist Martin Hudson, Lansing, for his instrumental part in the redesign of the 1980 *Michigan Medicine*.

EDITORIAL

Keep informed! Read Michigan Medicine and your "Medigram" newsletter

By James H. Tisdell, MD, Port Huron
Chairman, MSMS Committee on Publications



This is your medical journal.

Michigan State Medical Society, the Publications Committee, the editor, and all concerned with Michigan Medicine are dedicated to bring to the doctors of Michigan the best possible journal. We want it to be informative, helpful and responsive to the needs of our membership.

Four years ago we embarked on a major change in the format and intent of your journal. We did this because we believed we could serve you better, bringing to you the current events that affect your practice, your office and your family. Among state medical journals, the new Michigan Medicine was a first. Others, including the state society journals of Pennsylvania and Ohio, now are following our lead. Our journal received national recognition for the excellence of its design and content.

Our efforts to improve the immediacy, usefulness and attractiveness of the journal and Medigram continue. You will note several changes in the looks of this journal, designed to help guide the reader to the pertinent information. The 1980 journals have been reorganized a bit along lines of national news magazines. New features include this editorial column in which members of your Publications Committee will sound off each month. Michigan Medicine welcomes the comments of readers, and has moved the letters column to page 4 of each issue for better prominence.

Through our publications we have conducted opinion polls, have asked for criticism and suggestions so that we may give our readers what they want. Then why do we still hear some of our colleagues say, "What is so-and-so about? I've never heard of that before. What is going on with our leaders in East Lansing?"

This plea is like the minister admonishing his members on attendance. Those there to hear him don't need it, he says, and those that do aren't there to hear him.

How can we get information to all our members? We serve it up as deliciously as we can. Please, you faithful readers, inform all the members of your county societies, hospital groups and personal friends to read Michigan Medicine and "Medigram."

We want to have the most informed doctors in America. We face challenges from many groups and must have the facts to articulate our point of view on national, state and local issues.

Your journal and "Medigram" can keep you informed so that you will be able to converse with all groups on major problems concerning our profession.

We again ask you to let us know how you feel, and how you think we can improve our product.

Read our material and get your friends and colleagues to do the same. Keep informed!



Michigan State Medical Society
Warren F. Tryloff, director

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Judith Marr

Michigan Medicine, the official journal of the Michigan State Society, is dedicated to provide useful information for Michigan physicians about actions of the Michigan State Medical Society and contemporary issues, with special emphasis on socio-economics, legislation and news about medicine in Michigan. Major medical developments will be reported and interpreted as has been the custom.

The Michigan State Medical Society Committee on Publications is the editorial board of Michigan Medicine and advises the editors in the conduct and policy of the magazine, subject to the policies of the MSMS Council.

Neither the editors nor the state medical society will accept responsibility for statements made or opinions expressed by any contributor in any article or feature published in the pages of the journal. The views expressed are those of the writer and not necessarily official positions of the society. Products and services advertised in Michigan Medicine are neither endorsed nor warranted by MSMS.

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before treatment. If an allergic reaction occurs, discontinue the drug and treat with the usual agents (e.g., epinephrine or other pressor amines, antihistamines, or corticosteroids).

Precautions: Use with caution in individuals with histories of significant allergies and/or asthma. Do not rely on oral administration in patients with severe illness, nausea, vomiting, gastric dilatation, cardiospasm, or intestinal hypermotility. Occasional patients will not absorb therapeutic amounts given orally. In streptococcal infections, treat until the organism is eliminated (minimum of ten days). With prolonged use, nonsusceptible organisms, including fungi, may overgrow; treat superinfection appropriately.

Adverse Reactions: Hypersensitivity, including fatal anaphylaxis. Nausea, vomiting, epigastric distress, diarrhea, and black, hairy tongue. Skin eruptions, urticaria, reactions resembling serum sickness (including chills, edema, arthralgia, prostration), laryngeal edema, fever, and eosinophilia. Infrequent hemolytic anemia, leukopenia, thrombocytopenia, neuropathy, and nephropathy, usually with high doses of parenteral penicillin.

(102175)

*Equivalent to penicillin V.

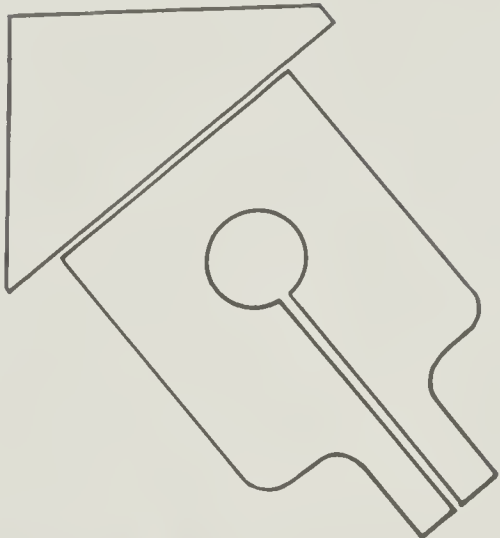
Additional information available to the profession on request.



Eli Lilly and Company
Indianapolis, Indiana 46206

900416

LETTERS



Thank you

I would like to thank the Michigan State Medical Society for allowing the Disability Determination Service of Michigan to display its exhibit at the Annual Scientific Meeting recently held at the Hyatt Regency Dearborn. It is really a privilege to have the opportunity to present our program to the physicians of Michigan. Improved understanding of our needs is a great help — not only to the physicians but for their patients. It helps us make better decisions as regards to eligibility for disability benefits.

We were most fortunate to have available for distribution our new handbooks for physicians along with some new brochures.

Our relationship with the Society has been most pleasant. Everyone has always been so gracious and helpful. We look forward to another year of continued association.

Harry D. Nesmith, MD
Chief Medical Consultant
Disability Determination Service
Bureau of Rehabilitation
Michigan Department of Education

* * *

I want to thank you for the excellent article concerning me and my grandfather in the November issue of the Michigan State Medical Society Journal. I have already had some excellent comments concerning it. The article is accurate in every way and is flattering to me, all of which I appreciate.

Richard D. Mudd, MD
Saginaw

"... the difficult decision of 'going bare'."

In his article, "Going Bare, Losing Its Respectability," (Michigan Medicine, November, 1979), Mr. R. Timothy Hogan erroneously discusses the necessity of transferring assets to escape a financial award against the physician in a malpractice action.

He has ignored Michigan's statutes which hold that any joint asset cannot be attached if held free and clear of financial encumbrances. This includes property held in joint ownership, stocks, and bank accounts. If the physician and his wife own a house in joint ownership with an outstanding mortgage, then the property can be attached. If it is paid for, it cannot be attached.

It is therefore, unnecessary to "sign away" one's assets. Other assets which have been placed in a trust if the trust was not created in anticipation of a law suit, also cannot be attached.

In the event of a substantial award, the physician may declare bankruptcy to avoid payment. This has a number of limitations, none of which is appealing.

One of the main reasons for the incorporated physician to avoid "going bare" status in Michigan is one which has escaped Mr. Hogan. The legal status of pension and profit-sharing plans being attached as a result of an award in a negligence action is unclear. The courts in Michigan have not had the occasion to make a decision. In California, the courts have held that pension and profit-sharing plans cannot be attached.

I would remind Mr. Hogan that "going bare" was never considered in the light of being respectable. At best, it is an act of desperation caused by totally unreasonable insurance premiums (\$30,000 for some neuro-, orthopedic, and high risk surgical specialists here in Michigan) and insurance companies withdrawing coverage from high risk specialists through "selective underwriting."

The power of states and hospitals to impose the requirement of professional liability insurance as criterion for licensure or staff membership has not been through the appellate process.

The calmer atmosphere Mr. Hogan describes which is true of the past three years is going to deteriorate. From all indications, there will be an escalation in medical negligence actions around the United States including Michigan within the next five or six years which will precipitate a crisis which will make the 1974 crisis seem minor. High risk specialists will again be confronted with the difficult decision of "going bare."

I do not advocate "going bare." However, physicians should be given correct, not misleading information to assist them in deciding alternatives.

John W. Grigg, MD
Bay City
Chairman
Professional Liability Committee
American Council of Otolaryngology

"...attack on pain."

Our Committee is composed of individuals from many fields — medical, legal, psychological, bioethical, religious, etc. — who are dedicated to waging an all-out attack on pain.

To begin this attack, we must see to it that our physicians no longer have their hands tied with a restricted drug armamentarium. Instead, we want you to have the flexibility of a diverse range of all effective analgesics to alleviate pain.

We ask you to join us in our campaign, and to give us your comments and suggestions to help with our program.

For a brochure describing our organization, please write to: National Committee on the Treatment of Intractable Pain, PO Box 34571, Washington, DC 20034.

Please let us hear from you.

Judith H. Quattlebaum
President and Executive Director

The primary beneficiaries of ORAL HYDERGINE® TABLETS, 1 mg (1 tab t.i.d.)

Each 1 mg Hydergine tablet contains dihydroergocornine mesylate 0.333 mg, dihydroergocristine mesylate 0.333 mg, and dihydroergocryptine (dihydro-alpha-ergocryptine and dihydro-beta-ergocryptine in the proportion of 2:1) mesylate 0.333 mg, representing a total of 1 mg.

They're in their late sixties, the beneficiaries of more liberal retirement laws and more enlightened attitudes toward the elderly. They're leading socially productive lives. But recently, without any clear cause, they had each begun to experience mild episodes of symptoms such as confusion, mood-depression, and dizziness. Their ability to function could have been jeopardized. That's when they became the beneficiaries of oral Hydergine therapy.



The still-functioning geriatric can benefit from Hydergine treatment

It is quite common for cognitive and emotional symptoms of deterioration to manifest gradually in the elderly. During this early stage, such symptoms are mild and more amenable to treatment. It is at this stage that Hydergine therapy has proved most effective. Patients tend to respond better, and with symptoms effectively relieved—or at least their progression retarded—the ability to function can be maintained.

Oral Hydergine tablets promote better patient compliance

Compared with the sublingual form, dosage administration is easier, with less need for supervision.

Contraindications: Hypersensitivity to the drug.

Precautions: Because the target symptoms are of unknown etiology, careful diagnosis should be attempted before prescribing Hydergine tablets and sublingual tablets.

Adverse Reactions: Serious side effects have not been found. Some sublingual irritation, transient nausea, and gastric disturbances have been reported. Hydergine tablets and sublingual tablets do not possess the vasoconstrictor properties of natural ergot alkaloids.

Dosage and Administration: 1 mg three times daily. Alleviation of symptoms is usually gradual and results may not be observed for 3–4 weeks.

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Before prescribing, see package insert for full product information.

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ELECTION 1980

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Michigan Conference on Maternal and Perinatal Health taking shape for March 5-6

by Bruce A. Work, Jr., MD and John W. Hallitt, MD,
Co-chairmen, 1980 Conference on Maternal and Perinatal Health



Great things are in store for MSMS members, nurses, and others who attend the 19th Annual Michigan Conference on Maternal and Perinatal Health to be held March 5-6 at the Hyatt Regency Dearborn.

The Conference has a new format, designed to make the usual fine product even better.

Rather than trying to cover a large number of topics in passing fashion, the planning committee this year has elected to cover fewer areas in greater depth.

The Wednesday morning session March 5 will deal with the latest technologies surrounding birth and the perinatal period. Topics to be covered by a number of leading practitioners of the techniques include ultrasonography, sensors, and monitors, followed by a structured panel discussion.

Following lunch the afternoon session will concentrate on infectious diseases and immunologic deficiencies that threaten the mother and/or infant. Included will be presentations on immunology, viral infections, lactation (with emphasis on the natural immunologic characteristics of mother's milk), and bacterial infections.

The Thursday morning session will deal with drugs and anesthetics during pregnancy and delivery, and will discuss their use in both high and low risk pregnancies. Another portion of the program will deal with permissible/prohibitible drugs followed by a segment on teratology.

Concluding the conference on Thursday afternoon will be a session dealing with understanding the special needs of the pregnant adolescent.

We urge interested Michigan physicians to plan now to attend the 1980 Michigan Conference on Maternal and Perinatal Health. The outstanding speakers on this year's program are spotlighted on the next two pages, and the program and an advance registration form are included in this special section.

The conference has been approved for 11 hours of Category I Credit and 11 hours of American Academy of Family Physicians' Prescribed Credit. Application has been made to the Michigan Nurses Association for its approval of the program for CEU credits for nurses.

1980 Conference is joint effort by 10 medical groups

While MSMS assumes the task of making physical arrangements, handling the publicity, registration, and a host of other activities related to the Michigan Conference on Maternal and Perinatal Health each year, the list of cooperating groups continues to grow. This year's meeting is made possible through the efforts of the following organizations:

- Michigan State Medical Society
- Michigan Academy of Family Physicians
- Michigan Chapter, American Academy of Pediatrics
- Michigan Department of Public Health
- Michigan Nurses Association
- Michigan Section, American College of Obstetricians and Gynecologists
- Michigan Section, Nurses Association, American College of Obstetricians and Gynecologists, District V
- Michigan Society of Obstetricians and Gynecologists
- Perinatal Association of Michigan
- Wayne County Medical Society

1980 conference planning committee includes multi-specialty representation

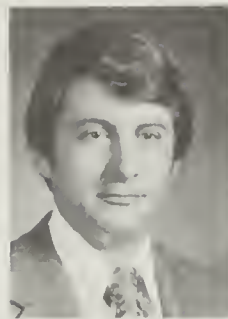
Members of this year's planning Committee for the Michigan Conference on Maternal and Perinatal Health include obstetricians, neonatologists, pathologists, pediatricians, family practitioners, internists, and nurses. Committee members are:

Bruce A. Work, Jr., MD,
Co-chairman
John W. Hallitt, MD, Co-chairman
Mohammad A. Aussie, MD
Linda D. Bond, RN
Robert C. Borer, MD

C. Arch Brown, MD
Laurence Bruggers, MD
Phyllis A. Carter, RN
Mary Conklin, RN
Barbara Colwell, RN
Miriam S. Daly, MD
Clinton H. Dowd, MD
Mary J. Kokosky, MD
Federico Mariona, MD
Donald T. Olson, MD
Ronald L. Poland, MD
Dietrich W. Roloff, MD
Mary Scoblic, RN
Lee B. Stevenson, MD



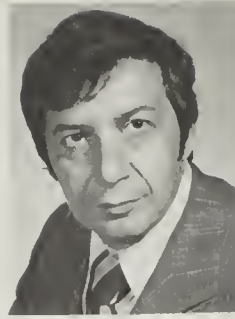
Barden



Bartholomew



Beer



Galask



Hinkle



Hohler

Twelve outstanding speakers scheduled for 1980 Maternal Health Conference

- **Tom E. Barden, MD**, Professor, Obstetrics/Gynecology
University of Cincinnati Medical Center

Monitors — "Biophysical Fetal Monitoring"

- **Edward G. Bartholomew, MD**, Assistant Professor,
WSU School of Medicine
Attending Anesthesiologist, Sinai Hospital, Detroit

Applied Anesthesiology — "Anesthesia for Low-Risk Obstetrics: A Clinical Review"

The anatomy of parturition, pertinent physiology and pharmacology will be discussed. The choice of anesthesia according to the stages of labor, as well as the advantages, disadvantages and complications of the major obstetrical anesthetics will be presented.

- **Alan E. Beer, MD**, Professor and Chairman
Department of Obstetrics and Gynecology
University of Michigan Medical School

Immunology — "Bonding, Breast Feeding, and Bugs"

Lactation — "Human Milk: Nature's Vaccine"

From the immunological, nutritional and other points of view, parturition represents the disconnection of the fetus from the two-way traffic exchange system afforded by the placenta to a substitution on a more intermittent basis by the one-way system afforded by the breast, the puerperal placenta. The mammary gland takes over a nutritional and immunological function that the placenta found far too dangerous to perform. Data will be reviewed that highlights the role of immunological effectors in milk that bridges the immunological gap that the neonate is faced with as he is thrust into the real world and thereby maintains the functional integrity of the neonate's gastrointestinal tract against a potentially hostile microbial environment.

- **Rudolph P. Galask, MD**, Professor
Obstetrics/Gynecology and Microbiology
University of Iowa Hospitals

Bacterial Infections — "Serious Infections in Obstetrics and Gynecology"

Infections contribute a significant part of the pathology encountered by the obstetrician and gynecologist. It is therefore imperative that a logical approach to infections in our specialty which is based on current knowledge be obtained. Therefore, newer concepts to the etiology and

management of various infections causing severe problems will be discussed.

- **Darlene T. Hinkle, BSN, MS**, Administrator
Improved Pregnancy Outcome Program
Michigan Department of Public Health
Division of Maternal and Infant Health

Adolescent Pregnancy — "Michigan Improved Pregnancy Outcome (IPO) Program"

The Michigan Improved Pregnancy Outcome Program has two primary goals: (1) to reduce the incidence of adolescent pregnancy (2) to improve the outcomes of pregnancies that occur to adolescents. The presentation will be a review of the implementation and development of the four Improved Pregnancy Outcome Project models in Michigan.

- **Charles W. Hohler, II, MD**, Assistant Professor
Maternal-Fetal Medicine Division
Department of Obstetrics and Gynecology
University of Southern California

Ultrasonography — "Dynamic Imaging of the Developing Fetus in the Obstetrician's Office: Pro and Con"

A revolution has quietly occurred in the past decade as diagnostic ultrasound has emerged from the research laboratory into routine hospital-based, and now office-based, obstetric and gynecologic practice. Rapid technological advances, especially with regard to linear and phased-array scanners, have made possible the development of this fascinating new tool in unparalleled fashion. Millions of women and their offspring have benefited from these developments and, if current trends continue to bring ultrasound into the office, it will soon be the rare woman who does not have an ultrasound at least once during pregnancy. This trend, however, has not occurred in a vacuum. Discussion will be based upon the speaker's personal experience with diagnostic ultrasound, results of a survey of twenty-five office obstetric practices using real-time equipment, how ultrasound fits into private practice care, its use as a "screening" tool, the medical, economic and legal risks and benefits.

- **Gertie F. Marx, MD**, Professor of Anesthesiology
Director of Obstetric Anesthesia
Albert Einstein College of Medicine
Bronx, NY



Marx



Philip



Poland



Sever



Stack



Weber

Applied Anesthesiology — "Anesthetic Considerations in Complications of Pregnancy"

In addition to covering general anesthetic considerations such as maternal position, maternal hyperoxia, vaginal delivery vs cesarean section, and regional analgesia vs systemic analgesia, special emphasis will be given to some abnormal situations: preeclampsia-eclampsia, diabetes mellitus, hemorrhage, and prematurity.

- **Alistair G. S. Philip, MD**, Associate Professor, Pediatrics
University of Vermont College of Medicine
Co-director,
Vermont/New Hampshire Regional Perinatal Program

Sensors — "Non-invasive Monitoring and Investigation of the Newborn Infant"

Non-invasive, continuous, transcutaneous monitoring of PO₂ provides a totally different perspective of the sick newborn infant. It has resulted in changes in both physician and nursing care. Transcutaneous monitoring of PCO₂ is now available and should provide equally valuable information.

The TcPO₂ sensor can also provide a non-invasive evaluation of blood pressure. Intracranial pressure measurements can be made continuously with a sensor placed over the anterior fontanel.

Together, these devices may detect, predict and subsequently prevent hemorrhagic or ischemic brain damage.

- **Marilyn L. Poland, PhD**, Assistant Professor
Department of Gynecology and Obstetrics
Wayne State University School of Medicine

Adolescent Pregnancy — "Sociocultural Aspects of Adolescent Pregnancy"

The continuing phenomenon of high rates of pregnancy in young adolescents reinforces the notion that current programs aimed at prevention are not working. Data from a Detroit population will be presented and a model identified that may be more appropriate to the health needs of adolescents.

- **John L. Sever, MD**, Chief
Infectious Disease Branch
National Institute of Neurological Diseases and Stroke
National Institutes of Health
Bethesda, MD

Viral Infections — "Herpes and Hepatitis"

Herpes viruses have become a major cause of venereal infections in the United States. When the virus is present at term, the child may become infected and 60% of these children die. Hepatitis B infection of the mother in the

last trimester or postpartum may be transmitted to the child with resulting persistent infection and liver damage.

Teratology — "Rubella: Success with Problems"

Rubella during the first five months of pregnancy may cause severe damage to the fetus. Rubella serology is being used to confirm clinical infections and to identify individuals at risk. Unfortunately, these tests are not always accurate. This results in considerable problems for the patient and physician.

- **Jack M. Stack, MD**, President
Family Health Research Foundation
and Service Institute
Alma, MI

Adolescent Pregnancy — "Decision Making by the Pregnant Adolescent"

One of the tasks of adolescence is the establishment of a love relationship outside of the nuclear family. Another task of adolescence is to separate from the family and establish an independent identity. One of the consequences of these tasks is often pregnancy.

This paper explores the dynamics of adolescent pregnancy resolution decision making. Decisions include abortion, have the baby and keep, and have the baby and adopt. The young woman's relationship to parents, friends, husband and/or male friend and caregivers is explored.

- **Wendell W. Weber, MD**, Professor of Pharmacology
University of Michigan Medical School

Permissible/Prohibitible Drugs — "Drugs and Smoking During Pregnancy"

There is much current interest in the effects of drugs and smoking on the outcome of pregnancy and maternal health. Most women can be reassured that medication prescribed sensibly and for a specific complaint is unlikely to harm the fetus. In some instances the risks of drug therapy are real but can be minimized when prescribing for pregnant women or for women of reproductive age whose pregnancy may be unsuspected by observing a few general principles and avoiding certain drugs. The case against smoking in pregnancy is still being debated, but there is little doubt that the effects of smoking on fetal development are manifold, and are both harmful and long-lasting. Although smoking stands out as an important determinant of small-for-dates babies and increased infant mortality, smoking among women of child-bearing age is more prevalent than ever, and attempts to influence smoking during pregnancy are not encouraging or strongly endorsed by medical practitioners.

Here is the program for 1980 Michigan Conference on Maternal and Perinatal Health

The program is approved for 11 hours of CME Category I Credit, and accepted for 11 Prescribed Hours by the American Academy of Family Physicians.

Wednesday Morning, March 5

8:45 a.m. **Ultrasonography** — "Dynamic Imaging of the Developing Fetus in the Obstetrician's Office: Pro and Con" — Charles W. Hohler, II, MD, assistant professor, Maternal-Fetal Medicine Division, Department of Obstetrics and Gynecology, University of Southern California, Los Angeles

9:30 a.m. **Sensors** — "Non-invasive Monitoring and Investigation of the Newborn Infant" — Alistair G. S. Philip, MD, associate professor of pediatrics, University of Vermont, College of Medicine, and co-director, Vermont/New Hampshire Regional Perinatal Program, Burlington

10:45 a.m. **Monitors** — "Biophysical Fetal Monitoring" — Tom E. Barden, MD, professor of obstetrics and gynecology, University of Cincinnati Medical Center

11:30 a.m. **Panel Discussion**

Wednesday Afternoon, March 5

1:30 p.m. **Immunology** — "Bonding, Breast Feeding, and Bugs" — Alan E. Beer, MD, professor and chairman, Department of Obstetrics and Gynecology, University of Michigan Medical School

2:15 p.m. **Viral Infections** — "Herpes and Hepatitis" — John L. Sever, MD, chief, Infectious Diseases Branch, National Institute of Neurological Diseases and Stroke, National Institutes of Health, Bethesda, MD

3:15 p.m. **Lactation** — "Human Milk: Nature's Vaccine" — Alan E. Beer, MD

4 p.m. **Bacterial Infections** — "Serious Infections in Obstetrics and Gynecology" — Rudolph P. Galask, MD, professor of obstetrics and gynecology and professor of microbiology, University of Iowa Hospitals

Thursday Morning, March 6

8:45 a.m. **Applied Anesthesiology** — "Anesthesia for Low-Risk Obstetrics: A Clinical Review" — Edward G. Bartholomew, MD, assistant professor, Wayne State University School of Medicine, and attending anesthesiologist, Sinai Hospital of Detroit

9:30 a.m. **Applied Anesthesiology** — "Anesthetic Considerations in Complications of Pregnancy" — Gertie F. Marx, MD, professor of anesthesiology, director of obstetric anesthesia, Albert Einstein College of Medicine, Bronx, NY

10:45 a.m. **Permissible/Prohibitible Drugs** — "Drugs and Smoking During Pregnancy" — Wendell W. Weber, MD, professor of pharmacology, University of Michigan Medical School, Ann Arbor

11:30 a.m. **Teratology** — "Rubella: Success with Problems" — John L. Sever, MD

Thursday Afternoon, March 6

1:30 p.m. **Adolescent Pregnancy** — "Decision Making by the Pregnant Adolescent" — Jack M. Stack, MD, president, Family Health Research Education and Service Institute, Alma — "Sociocultural Aspects of Adolescent Pregnancy" — Marilyn L. Poland, PhD, assistant professor, Department of Gynecology and Obstetrics, Wayne State University School of Medicine — "Michigan Improved Pregnancy Outcome (IPO) Program" — Darlene T. Hinkle, BSN, MS, administrator, Improved Pregnancy Outcome Program, Michigan Department of Public Health, Division of Maternal and Infant Health

Advance Registration

Please complete and mail to the Michigan Conference on Maternal and Perinatal Health, Box 950, East Lansing, MI 48823

Name _____

Please check one:

Address _____

Physician RN LPN Student Other

City _____ Zip _____

☐ ☐ ☐ ☐ ☐

Registration Fee:

Physician Nurse Other Student/House Officer

Please Check Wednesday Sessions

☐ \$15

☐ \$8

☐ \$8

☐ No Charge

Thursday Sessions

☐ \$15

☐ \$8

☐ \$8

☐ No Charge

Total

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\$ (none)

Make checks payable to Michigan State Medical Society

Blues reform legislation top issue for new BCBSM medical director

By Shelton Reece, Special to Michigan Medicine

Armen Shekerjian, MD, is a communicator as well as a Blue Cross and Blue Shield of Michigan vice president and medical director. He has an open, freindly, let's-get-things-done manner. He expresses concern for, and knowledge of, the health care field and an ability to analyze a problem and suggest solutions faster than many would take simply to define the situation.

His experience is broad and varied. He appears to be eminently suited for his new position.

A native Detroit, Doctor Shekerjian has been a medical consultant with the Michigan Department of Public Health, has practiced general surgery in the Detroit area for more than 20 years, served as assistant medical director for Detroit Edison, and was a physician and consultant to HMO International in Los Angeles. He earned his medical degree from Wayne State University, a master's degree in medical care administration from the University of Michigan, and attended the Harvard Graduate School of Business program for Health Systems Management.

Memberships

He is a member of the Academy of Surgery of Detroit, Michigan Society of General Surgeons, Detroit Surgical Society, American Occupational Medical Association, the AMA, MSMS and the Oakland County Medical Society. Doctor Shekerjian is also a Fellow in the American College of Surgeons and the American College of Emergency Physicians.

His views on subjects of interest to *Michigan Medicine* readers can perhaps best be determined by his responses to the questions we posed:

Question: How can Blue Cross and Blue Shield of Michigan (BCBSM) and the medical profession better work together for cost con-



Doctor Shekerjian

tainment and improved reimbursement activities?

Answer: "From my perspective, the pivotal factors in an improved relationship between the medical profession and BCBSM are open avenues of communication and an atmosphere of mutual respect and trust. I would like more timely input of factual information from physicians, and to respond in a like fashion. By operating in this fashion, we will better appreciate the problems relating to medical care costs, and, hopefully, that will lead us to more appropriate resolutions, particularly in the areas of cost containment and reimbursement.

"Within the parameters of cost, availability of health care, and the quality of such care, I am sure we all recognize that some constraints are necessary in the allocation of health care resources."

Question: In your opinion, how does the current FTC suit affect BCBSM's relationship with MSMS?

Answer: "It is impossible to predict the consequences of the government's action to BCBSM/MSMS relations.

"However, we do believe that as a service benefit corporation, BCBSM's board of directors must obtain information and advice from knowledgeable entities before the board itself can be reasonably knowledgeable.

"The operation of a medical care corporation would, for all practical purposes, be impossible, if consultation and cooperation with provider groups, such as MSMS, were barred. The board must be able to hear the legitimate concerns of Michigan physicians as well as other providers, subscribers and groups."

Question: Please discuss the new Health Care Cost Committee program.

Answer: "An essential component of the cost containment program, approved by the BCBSM Board in July, 1979, is the regional committee structure.

"The 10 regional divisions evolved from the original plan of utilizing the 15 Councilor Districts of Michigan State Medical Society. The district's boundaries subsequently were modified to create a more manageable number of regions as well as to reflect information obtained from the Michigan Health Data Corporation on where patients were seeking medical care services.

"These Regional Committees will be formed by the BCBSM Health Care Cost Committee (HCCC) initially to review excessively high utilization and expenditure areas.

"The first area of consideration will be the 'I-75 Corridor' covering Wayne, Oakland, Macomb, Washtenaw and Livingston Counties. (Regions should be identified by early 1980, and, at least the initial ones, should be operational by mid-year.)

"Regional Committees will have a seven-person membership, (three consumers, two MD's, one DO and a representative of independent interests). We expect the regional commit-

SHEKERJIAN/continued

tees to draw upon other individuals when issues arise beyond the expertise and knowledge of the regular membership.

"The Committees will:

- "Verify whether a cost containment problem exists within the region relating to the region's characteristics and the statewide goal level;

- "Conduct an inquiry into the nature of the problem through solicitation of information pertaining to contributing factors and possible solutions;

- "Recommend to HCCC remedial actions to be taken by BCBSM and other groups or individuals; and

- "Monitor implementation of actions as approved by BCBSM and their impact on the problem(s) as identified.

"I want to stress that the Committees will not be looking for skeletons in the closet. What we are concerned with here will be abnormally high costs and how they can be adjusted without impairing the quality of the patient's care."

Question: What are the big issues in health care delivery from the BCBSM point of view at this time?

Answer: "Basically, we are very concerned about Michigan House Bill 4555, which we view as too restrictive. As now written, the bill would re-design the corporate structure and functions of BCBSM.

"This bill would inject state government into the policy-making process of the corporation's board of directors. This is not right in any sense of the word, as government and politics have no place in the boardroom of any private corporation.

"Government over-regulation is inherent in this bill.

"The proposed legislation gives the state insurance commissioner the power to appoint a voting member to the corporation's board of directors. This seems to be a blatant conflict of interest: the insurance commissioner regulates the corporation, and also appoints a board member.

"Government intrusion into the private business sector goes even further in this bill.

"Under provisions of the bill, Blue Cross and Blue Shield of Michigan would be forced to divulge trade secrets and confidential health care information about its customers. You

don't want that, and neither do I.

"It could cripple Blue Cross and Blue Shield of Michigan's ability to compete in the marketplace and serve its more than 5,000,000 customers.

"This is a dangerous precedent. If permitted, this bill could pave the way for the same over-regulation, take-over approach to financial institutions, hospitals, labor unions, food chains or any other organization dealing with the public.

"Government regulation is not the issue. The key concern is whether this bill is a rational and responsible use of government power.

"We believe it is excessive.

"BCBSM believes that any final legislation should include the following provisions:

- "BOARD STRUCTURE: The board should include at least 75 percent customer representatives, allocated proportionally between those who pay for the coverage. Board members themselves should determine details of how the board will function.

- "RATE PROCESS: Once the company has filed a rate request, it wants a firm time deadline for either a final decision by the commissioner or automatic interim rate relief. In case of disputes, the company wants impartial hearings by hearing officers nominated by the American Arbitration Association, with the findings of fact binding on the commissioner.

- "BENEFITS: Benefit packages should be determined solely by employers, in keeping with what they want, need and can afford, or determined by collective bargaining.

- "CONFIDENTIALITY: The company's private business information should be treated no more and no less confidentially than that of any competitor conducting operations in Michigan.

- "CORPORATE POWERS: The company should be allowed to market the same range of services as its competitors, including "packaged" employee benefits and Administrative Services Arrangements.

- "RESERVES AND INVESTMENTS: Reserves should be allowed to assure stability of rates and to allow normal seasonal variations in our business. Investment regulations should be the same as those applied to commercial insurers.

Question: What will health care be like in the year 2000?

Answer: "There is little doubt of changes in the present fee-for-service structure, but I believe the preponderance of care will be provided basically in the same mode as today, particularly in areas with large populations. There will be alternate opportunities such as IPA's, HMO's and others, but I feel patients will still elect to choose their own physician and, when necessary, pay the difference in cost.

"I believe we will finally recognize that good medical care is expensive, based on the tremendous advances in technology which will continue, the increased quality of care patients expect, as well as the increased use of medical facilities by patients.

"Educational programs probably will be greatly expanded, and by that time we will see more paraprofessionals, and others, who will provide more of the basic primary type attention.

"There will be many decisions made concerning life-prolonging techniques, and we will probably see exciting progress in that area."

Question: How do you personally plan to influence BCBSM as its new medical director?

Answer: "I basically have two major charges. These are: overall responsibility for the medical policies of the corporation, and to act as management spokesman for the profession.

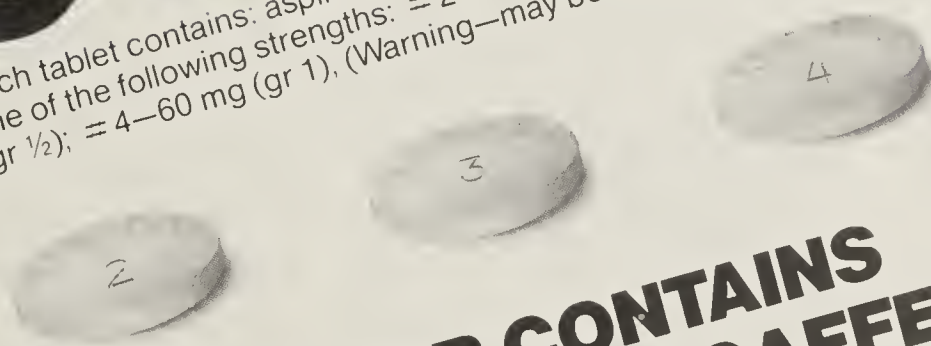
"In the new organizational framework, all physicians at BCBSM report to me, and I hope to strengthen the service that is offered by the medical director's and medical affairs groups.

"As spokesman for the profession in terms of our corporation, I will seek to influence policies that are beneficial to BCBSM and to the medical community. While I may not always agree entirely with all policies, I should be able to have some meaningful input into them.

"One of my most important goals is to develop excellent communications with members, in an open, give-and-take manner, which I trust will prove helpful to all concerned . . . particularly to the patient."

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MSMS member service subsidiary's new programs generating enthusiasm

By Judith Marr, editor



Members of the MSMS/PSG, Inc. staff handling the new member service projects: left to right, John H. Anthony, general manager; Meredith Fors, projects coordinator; Robert Stanziano, director of financial services, and Patti Sproot, secretary.

Recently an MSMS member — a director of his local bank — became intrigued with the estate planning services of the new MSMS subsidiary, the Physician Service Group, Inc. He had loyalties to his local bank, and was planning to keep that bank involved in his estate plans. But the PSG package was so attractive to the physician and his wife, that he went with the Physician Service Group Plan instead.

According to Leland E. Holly, II, MD, PSG President, that was a typical reaction of MSMS members to one of the services offered by PSG, and the other services have been equally well received. Doctor Holly and the staff of the Physician Service Group, headed by John Anthony as General Manager, generate great enthusiasm in their descriptions of several PSG programs already underway for MSMS members, and many others in preparation or under investigation. They include:

- The estate planning services,

the bailiwick of Robert Stanziano, director of financial services for PSG. Mr. Stanziano, formerly vice president and senior trust officer of Michigan National Bank, finds both physicians and their spouses enthusiastic about the estate planning program which has, as a cornerstone, the goal of full participation and understanding by the spouse.

- The practice management consultation program carried out by Mr. Anthony. He visits with physicians in settings ranging from one-person offices to multi-specialty groups to major metropolitan medical clinics.

His expert advice after on-site evaluation has enabled the clients to more efficiently manage office personnel and setup. Mr. Anthony has made 15 consultations in the past five months, has another 20 lined up and has 300 inquiries from interested physicians.

- The PSG-endorsed bill-collecting service for physicians, carried out by I.C. Systems, a national

firm with an office near Lansing. The PSG bill-collecting service currently is serving 1,200 Michigan physicians.

- The member loan program which provides \$5,000-\$25,000 unsecured loans to MDs. The program was just offered to MSMS members in October. It required no collateral, only the physician's signature on the papers. Over 25 inquiries already had been made by interested physicians before the loan program became operational.

- The credit card bill collecting program, with arrangements completed this month. It allows patients to put their physicians' bills on their credit card, at a very favorable discount rate to the physician.

- The master pension plan which has been in the works the past year and which is expected to be in operation early next year. Every MSMS member will be eligible for this pooled trust pension program, and a large percent of members polled have indicated an interest in joining.

Seriously under current study are a group purchasing plan for medical supplies and equipment, which would take advantage of group rates and lower medical care costs; and a tax shelter program which would invest after-tax dollars in apartment buildings and condominiums. The benefits would accrue to MSMS members, while the PSG would handle day-to-day responsibilities of property management.

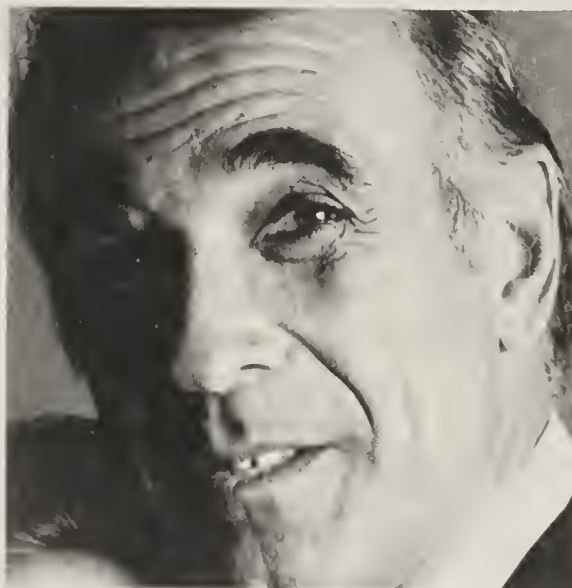
PSG advantages

The advantages to MSMS members in these Physician Service Group programs are several, explains Mr. Anthony.

"We work for the MSMS members directly," he says. "We are the members' employees, whether out on

continued on page 16

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MSMS members volunteering on area sports medicine clinics

By Vern Norris, executive director,
Michigan High School Athletic Association

The growing interest in sports medicine over the past 10 years is demonstrated by increasing attendance at the annual MSMS Conference on the Medical Aspects of Organized Athletics. More and more high schools and colleges throughout Michigan send coaches, trainers and team physicians to this annual event to learn the latest in treatment and prevention of athletic injuries.

MSMS long has cooperated with the Michigan High School Athletic Association in providing physician speakers for local sports medicine clinics. Additionally, MSMS has actively urged Michigan doctors to make themselves available to serve as team physicians. Hundreds of physicians have given thousands of hours in this effort over the years.

Now MSMS has taken a step to assist the MHSAA in another way.

During the 1978-79 school year, a survey of schools was conducted to determine the number of sports medicine clinics conducted the preceding year. Over 35 such clinics were reported, but few were widely publicized so that school administrators and coaches could make themselves available on the scheduled dates.

The Michigan High School Athletic Association followed up by requesting schools to host clinics during the 1979-80 school year.

Fourteen sites were selected and the hosting schools determined dates and times for the clinics. Clinics already have been held at the following sites: Pigeon: Elkton-Pigeon-Bay Port Community Schools; Elsie: Ovid-Elsie

High School, Sturgis High School, Lawton High School, Riverview High School, Traverse City High School; Delton: Delton-Kellogg High School, Oxford High School; Roseville: Brab-Roseville: Brablec High School. Clinics still to be held include those at: Dearborn: Divine Child High School, March 25; Escanaba High School, March 29; Lansing: Everett High School, March 31; Grand Rapids: Central High School, April 1; Ann Arbor: Pioneer High School, May 10.

MSMS members have volunteered their services for meetings at each of the sites. The programs will vary, but all will include the basics of CPR application, recognition of heat prostration, conditioning, proper taping and warm-up techniques.

The goal of the clinics is to upgrade the knowledge and application of appropriate sports medicine to nonfaculty coaches, as well as professional staff members on the coaching staff of each Michigan high school.

The 14 clinics sponsored by the MHSAA and the MSMS supplement the annual MSMS Sports Medicine Conference and, we hope, will encourage every community to become involved in the care and prevention of injuries at all levels of athletic competition.

Ideally, physicians attending the 1980 MSMS Conference on the Medical Aspects of Organized Athletics April 10 at Long's Convention Center in Lansing will become resource persons for local clinics in their areas.

PSG/continued

a consultation, helping draw up an estate plan or collecting bills. We're being commissioned by the members to do the best for them.

"We offer savings because we are dealing for a large group of persons and can gain the economies of scale.

"Everything is geared to a homogeneous group — physicians.

"We're going directly from manufacturer to buyer — eliminating the middle man. In essence, we are physicians when we deal with the providers of goods and/or services we want for MSMS members."

The PSG also provides services to specialty societies on a contract basis. The Physician Service Group was incorporated in September, 1978, by The Council, MSMS, and is a wholly-owned taxable subsidiary of the MSMS membership. The board of directors is elected by The Council. PSG President Holly from Muskegon also is MSMS Treasurer.

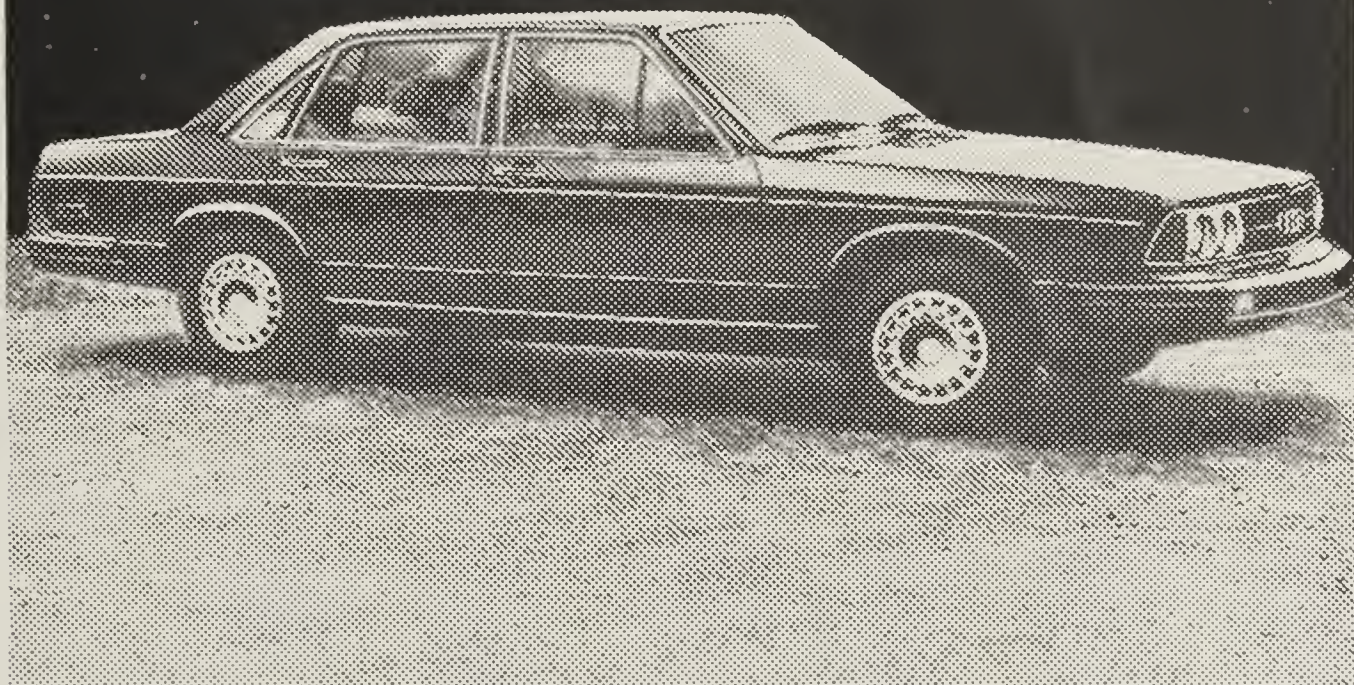
Michigan Medicine and Medi-gram articles during the past year and a half have described the progress of the PSG, with an entire section of the May 1979 issue of Michigan Medicine devoted to the description of the PSG's organization and purposes.

MSMS members may contact the Physician Service Group at 1305 Abbott Road, East Lansing, 48823 (tel: 517/337-1351).



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MPMLC CLIPSHEET

MPMLC Clipsheet is intended to inform Michigan doctors about the Michigan Physicians Mutual Liability Company and its activities. Additional information may be obtained by contacting MPMLC at P.O. Box 1471, East Lansing, MI 48823; phone 1-800-292-1926 toll free, or 517-351-1150.

Michigan Physicians Mutual launches property, general liability coverage

Michigan Physicians Mutual Liability Company has entered the property and general liability insurance field with MEDGARD, an entirely new concept in building and office contents coverage.

Designed exclusively for physicians, the new policy is written in understandable language and provides "all risk" replacement insurance for property, as well as premises liability and medical payments.

Because it was developed to meet special needs, MEDGARD contains unique coverage features that realistically relate to medical practice. These include:

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- Non-owned automobile liability

Employee dishonesty coverage and a number of other items may be added for an additional premium.

At very competitive cost, MEDGARD is available to members of the Michigan State Medical Society. MEDGARD insureds are not required to own a surplus certificate or to carry professional liability insurance through MPMLC.

Complete information may be obtained by calling MPMLC's toll free number, 1-800-292-1926, or by writing to P.O. Box 1471, East Lansing, Michigan 48823.

* * *

The Michigan insurance commissioner has affirmed MPMLC's financial health by removing all restrictions in MPMLC's certificate of authority. Now MPMLC is fully authorized to offer any type of property-casualty insurance, subject only to the usual regulatory oversight applied to established insurance companies.

The commissioner's August 16 order states:

"MPMLC has grown considerably in the three years of the company's existence . . . Corporate assets are in excess of \$37 million, and earned surplus was over \$900,000 on March 31, 1979. Following a first year operating loss, the company has recorded statutory gains during the second and third year operations.

"Upon review of the operating history of MPMLC, the insurance bureau staff concurs with the MPMLC in the belief that the available evidence and experience indicates that the company is operating in a financially safe and reliable manner."

Since its birth in 1976, MPMLC had operated under limitations imposed by the insurance bureau to ensure that MPMLC would become and remain financially sound. The original certificate of authority restricted MPMLC to offering medical malpractice insurance with maximum policy limits of \$100,000 per occurrence and \$300,000 annual aggregate. A 1977 amendment enabled MPMLC to offer \$200,000/\$600,000 limits.

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MEETINGS



MSMS, MSMS/A, AMA, and medical assistants

Jan. 23 — MSMS Council, MSMS headquarters, contact: Warren Tryloff, MSMS headquarters.

Jan. 25 — MSMS/Intrav South American Adventure, contact: Marcelyn Ireland, MSMS headquarters.

Feb. 2-3 — Mid-Winter Seminar, State of Michigan Branch, American Association of Medical Assistants, Weber's Inn at Ann Arbor, contact: Frances Drawe, 2171 Medford, Apt. 33, Ann Arbor, 48104.

Feb. 21-24 — 8th Annual AMA National Leadership Conference, Downtown Marriott Hotel, Chicago, contact: AMA, 535 N. Dearborn, Chicago, IL 60610.

March 5 — MSMS Council, MSMS headquarters, contact: Warren Tryloff, MSMS headquarters.

March 5-6 — MSMS Conference on Maternal and Perinatal Health, Hyatt Regency Dearborn, contact: Katie Brewbaker, MSMS headquarters.

March 9 — Board Meeting, State of Michigan Branch, American Association of Medical Assistants, MSMS headquarters, contact: Caroline Rich, MSMS headquarters.

April 10 — MSMS Conference on Medical Aspects of Organized Athletics, Long's, Lansing, contact: Mert Scholten, MSMS headquarters.

April 17 — AMA 33rd National Conference on Rural Health, Sheraton-Boston, contact: Barbara Chapman

312/751-6604 or Gary Schwartz 312/751-6431.

April 17-19 — Annual Convention and House of Delegates, State of Michigan Branch, American Association of Medical Assistants, Hilton Inn at Plymouth, contact: Margaret Broadwell, 16686 East Eight Mile Rd., Detroit, 48205.

April 25-27 — 1980 MSMS House of Delegates, Michigan Inn, Southfield, contact: Richard Campau, MSMS headquarters.

July 10-13 — MSMS Council, Holiday Inn, Marquette, contact: Warren Tryloff, MSMS headquarters.

Sept. 10 — MSMS Council, MSMS headquarters, contact: Warren Tryloff, MSMS headquarters.

Oct. 22 — MSMS Council, MSMS headquarters, contact: Warren Tryloff, MSMS headquarters.

Dec. 3 — MSMS Council, MSMS headquarters, contact: Warren Tryloff, MSMS headquarters.

Other Meetings

Feb. 9-10, March 22-23, April 26-27, May 17-18 — Sexuality Training for Professionals, at Michigan League, Ann Arbor, contact: Michael Brown, 6869 Marshall Rd., Dexter, 48130, 313/426-2334.

Feb. 13 — Membership Meeting sponsored by Michigan Dermatological Society, Henry Ford Hospital, Detroit, contact: Alejandro Morales, MD, Dept. of Dermatology, Henry Ford Hospital, 2799 W. Grand Blvd., Detroit, 48202.

March 5 — Membership Meeting sponsored by Michigan Dermatological Society, University of Michigan, Ann Arbor, contact: Alejandro Morales, MD, Dept. of Dermatology, Henry Ford Hospital, 2799 W. Grand Blvd., Detroit, 48202.

April 7 — Wayne County Medical Society Beaumont Lecture, Henry Ford Hospital, contact: Roger Mecum, 1010 Antietam, Detroit, 48207, 313/963-1640.

May 1-2 — Annual Meeting and Resident Surgeons Day, Michigan Chapter, American College of Surgeons, at Detroit, contact: J. H. McLaughlin, MD, 604 N. Woodward, Birmingham, 48011.

May 2 — Annual Meeting, Michigan Society of Thoracic Surgeons, at Detroit, contact: Rodman E. Taber, MD, Michigan Society of Thoracic Surgeons, 30050 Hoover Rd., Warren, 48093.

May 7 — Executive Committee Meeting, Michigan Allergy Society, at Henry Ford Hospital, Detroit, contact: Benjamin Stone, MD, 1005 Abbott Rd., East Lansing, 48823.

May 29-31 — 1980 American Hospital Association National Conference on Trustees, Renaissance Center, Detroit, contact: American Hospital Association, 840 N. Lakeshore Dr., Chicago, IL 60611.

June 7-8 — Spring Symposium, Michigan Otolaryngological Society, at Bay Valley Inn, Bay City, contact: Dieter Wendling, MD, Macomb Ear, Nose and Throat Center, 14 Bellevue, Mt. Clemens, 48043.

June 13-15 — Annual Meeting, Michigan Dermatological Society, Bay Valley Inn, Bay City, contact: Alejandro Morales, MD, Dept. of Dermatology, Henry Ford Hospital, 2799 W. Grand Blvd., Detroit, 48202.

June 13-15 — Annual Meeting, Michigan Chapter, American College of Chest Physicians, at Boyne Highlands, Boyne City, contact: Susan Gibson, American Lung Association of Southeast Michigan, 28 W. Adams, Detroit, 48226, 313/961-1697.

July 8-10 — Annual Scientific Meeting, Michigan Chapter, American Academy of Pediatrics, Bay Valley Inn, Bay City, contact: Miles Tiernan, 32245 Hearthstone, Farmington Hills, 48018, (313) 553-3646.



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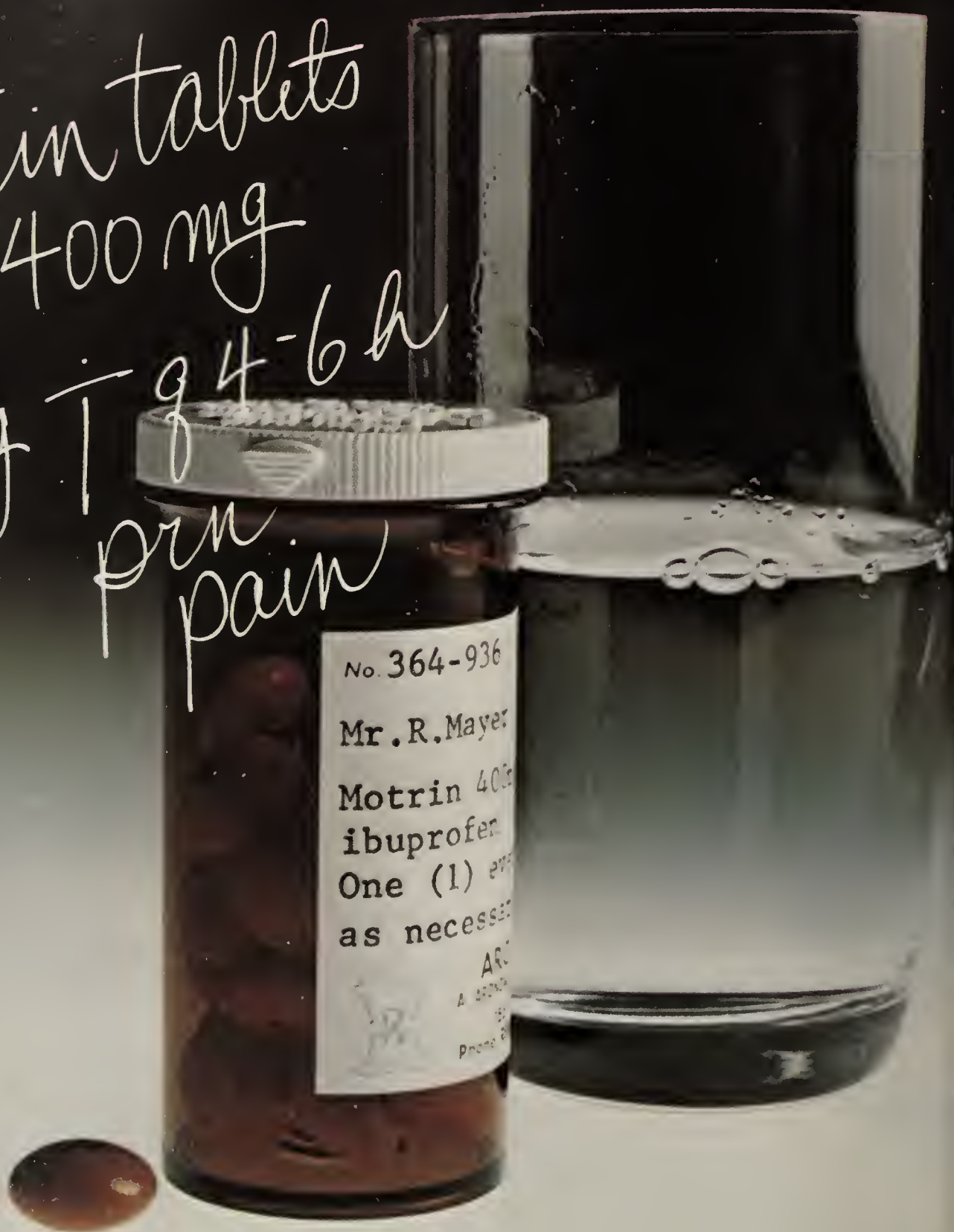
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	Darvon 65 mg propoxyphene	.66 (100)	.99 (99)	1.13 (96)	.99 (96)	.80 (96)
Statistical significance		p<0.02	p<0.01	p<0.05	p<0.02	p<0.002

*0 = No relief 1 = Partial relief 2 = Complete relief

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Relief of mild to moderate pain.

Contraindications: Individuals hypersensitive to it, or with the syndrome of nasal polyps, angioedema and bronchospastic reactivity to aspirin or other nonsteroidal anti-inflammatory agents (see WARNINGS).

Warnings: Anaphylactoid reactions have occurred in patients with aspirin hypersensitivity (see CONTRAINDICATIONS).

Peptic ulceration and gastrointestinal bleeding, sometimes severe, have been reported. Ulceration, perforation, and bleeding may end fatally. An association has not been established. Motrin should be given under close supervision to patients with a history of upper gastrointestinal tract disease, only after consulting ADVERSE REACTIONS.

In patients with active peptic ulcer and active rheumatoid arthritis, nonulcerogenic drugs, such as gold, should be tried. If Motrin must be given, the patient should be under close supervision for signs of ulcer perforation or gastrointestinal bleeding.

Precautions: Blurred and/or diminished vision, scotomata, and/or changes in color vision have been reported. If these develop, discontinue Motrin and the patient should have an ophthalmologic examination, including central visual fields.

Fluid retention and edema have been associated with Motrin; use with caution in patients with a history of cardiac decompensation.

Motrin can inhibit platelet aggregation and prolong bleeding time. Use with caution in persons with intrinsic coagulation defects and those on anticoagulant therapy.

Patients should report signs or symptoms of gastrointestinal ulceration or bleeding, blurred vision or other eye symptoms, skin rash, weight gain, or edema.

To avoid exacerbation of disease or adrenal insufficiency, patients on prolonged corticosteroid therapy should have therapy tapered slowly when Motrin is added.

Drug interactions. Aspirin used concomitantly may decrease Motrin blood levels.

Coumarin: Bleeding has been reported in patients taking Motrin and coumarin.

Pregnancy and nursing mothers: Motrin should not be taken during pregnancy or by nursing mothers.

Adverse Reactions

Incidence greater than 1%

Gastrointestinal: The most frequent type of adverse reaction occurring with Motrin is gastrointestinal (4% to 16%). This includes nausea,* epigastric pain,* heartburn,* diarrhea, abdominal distress, nausea and vomiting, indigestion, constipation, abdominal cramps or pain, fullness of the GI tract (bloating and flatulence). **Central Nervous System:** Dizziness,* headache, nervousness. **Dermatologic:** Rash* (including maculopapular type), pruritus. **Special Senses:** Tinnitus. **Metabolic:** Decreased appetite, edema, fluid retention. Fluid retention generally responds promptly to drug discontinuation (see PRECAUTIONS).

*Incidence 3% to 9%.

Incidence less than 1 in 100

Gastrointestinal: Upper GI ulcer with bleeding and/or perforation, hemorrhage, melena. **Central Nervous System:** Depression, insomnia. **Dermatologic:** Vesiculobullous eruptions, urticaria, erythema multiforme. **Cardiovascular:** Congestive heart failure in patients with marginal cardiac function, elevated blood pressure. **Special Senses:** Amblyopia (see PRECAUTIONS). **Hematologic:** Leukopenia, decreased hemoglobin and hematocrit.

Causal relationship unknown

Gastrointestinal: Hepatitis, jaundice, abnormal liver function. **Central Nervous System:** Paresthesias, hallucinations, dream abnormalities. **Dermatologic:** Alopecia, Stevens-Johnson syndrome. **Special Senses:** Conjunctivitis, diplopia, optic neuritis. **Hematologic:** Hemolytic anemia, thrombocytopenia, granulocytopenia, bleeding episodes. **Allergic:** Fever, serum sickness, lupus erythematosus syndrome. **Endocrine:** Gynecomastia, hypoglycemia. **Cardiovascular:** Arrhythmias. **Renal:** Decreased creatinine clearance, polyuria, azotemia.

Overdosage: In cases of acute overdosage, the stomach should be emptied. The drug is acidic and excreted in the urine, so alkaline diuresis may be beneficial.

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MED B-4-S

General surgeons draw most cases; great majority settle for under \$10,000

By John Richards, chief, MSMS Bureau of Economics

The MSMS Bureau of Economics has begun analysis of data gathered on 906 malpractice claims. These claims all completed the legal process between early 1974 and July 1979, and involved Michigan MDs. Following are highlights of the data.

Physician information

I. Average age of physician involved — 43 years

Age Distribution *

30 years and under — 12

Age 31-40 — 250

Age 41-50 — 325

Age 51-60 — 176

60 years and over — 72

II. Percentage of foreign medical graduates — 17% (Approximately 26% of Michigan MDs are FMGs.)

II. Number of board certified physicians sued — 610 (67.3%)

IV. Type of Practice

A. Academic/Institutional — 13 suits

B. PC or Partnership — 320 suits

C. Self-employed — 536 suits

D. Employed — 55 suits

E. Intern/Resident — 0 suits

V. Specialty (See Table I.)

Plaintiffs' characteristics

I. Sex distribution

A. Males — 347 (38.3 percent)

B. Females — 559 (61.7 percent)

II. Age distribution

Under 1 year — 32

Age 1-10 — 31

Age 11-20 — 78

Age 21-30 — 163

Age 31-40 — 140

Age 41-50 — 122

Age 51-60 — 101

Age 61-70 — 31

Age 71-80 — 16

Age 81-91 — 5

*Totals will not equal 906 due to the fact that not every form was complete.

TABLE I

Suits by AMA Specialty Classification

Allergy	1	Pediatrics	7
Anesthesiology	17	Physical Medicine and Rehabilitation	6
Cardiovascular Diseases	6	Psychiatry	9
Dermatology	5	Pulmonary Diseases	1
Emergency Medicine	16	Radiology, Diagnostic	15
Family Practice	16	Rheumatology	2
Gastroenterology	2	Rhinology	7
General Practice	121	Surgery, Abdominal	6
Geriatrics	1	Surgery, Cardiovascular	11
Gynecology	24	Surgery, Colon and Rectal	1
Internal Medicine	58	Surgery, General	354
Neurology	4	Surgery, Hand	3
Neurology, Child	3	Surgery, Neurological	14
Nuclear Medicine	2	Surgery, Orthopedic	93
Obstetrics	1	Surgery, Pediatric	6
Ophthalmology	10	Surgery, Plastic	23
Otology	1	Surgery, Thoracic	14
Otorhinolaryngology	5	Surgery, Traumatic	1
Pathology	8	Miscellaneous	21

Elapsed time to complete legal process

I. Average between injury and reporting date — 18 months

II. Average between injury and final disposition — 48 months

III. Average between reporting and final disposition — 30 months

Characteristics of claims settlement

I. Number of claims with no indemnity paid — 440 (48.6%)

II. Total indemnity paid 1974-June 1979 — \$6,349,312.00

III. Average indemnity per suit — \$6,879.00

IV. Average indemnity per suit with indemnity — \$13,625.13

V. Distribution of claims paid in thousands of dollars — (See Table II.)

TABLE II

Distribution of claims paid in thousands of dollars

0 - \$10,000	353
\$11,000 - \$20,000	43
\$21,000 - \$30,000	19
\$31,000 - \$40,000	7
\$41,000 - \$50,000	11
\$51,000 - \$60,000	3
\$61,000 - \$70,000	3
\$71,000 - \$80,000	5
\$81,000 - \$90,000	4
\$91,000 - \$100,000	12
\$101,000 - \$200,000	6

continued on page 26

VI. Geographical distribution of claims — (See Table III.)

TABLE III
Geographical distribution of claims

<i>Zip Code</i>	<i>Counties Included</i>	<i>Number of Claims</i>
480	Macomb, Oakland, St. Clair	246
481	Livingston, Monroe, Oakland, Washtenaw, Wayne	122
482	Wayne	187
484	Genesee, Huron, Lapeer, Oakland, Sanilac	8
485	Genesee	29
486	Arenac, Clare, Gladwin, Midland, Ogemaw, Oscoda, Roscommon, Saginaw	17
487	Alcona, Bay, Iosco, Tuscola	6
488	Clinton, Eaton, Gratiot, Ingham, Ionia, Isabella, Livingston, Shiawassee	24
489	Ingham	34
490	Allegan, Barry, Branch, Calhoun, Cass, Kalamazoo, St. Joseph, Van Buren	57
491	Berrien	0
492	Calhoun, Hillsdale, Ingham, Jackson, Lenawee	22
493	Kent, Lake, Mecosta, Montcalm	4
494	Mason, Muskegon, Newaygo, Oceana, Ottawa	21
495	Kent	23
496	Antrim, Benzie, Grand Traverse, Kalkaska, Leelanau, Manistee, Missaukee, Osceola, Wexford	10
497	Alpena, Charlevoix, Cheboygan, Chippewa, Crawford, Emmett, Luce, Mackinac, Montmorency, Ostego, Presque Isle	12
498	Alger, Delta, Dickinson, Marquette, Menominee, Schoolcraft	12
499	Baraga, Gogebic, Houghton, Iron, Keweenaw, Ontonagon	6

VII. Average indemnity paid by geographic region — (See Table IV.)

TABLE IV
Average indemnity paid by geographic region

<i>Zip Code</i>	<i>Counties Included</i>	<i>Average Indemnity Paid</i>
480	Macomb, Oakland, St. Clair	\$ 5,902.17
481	Livingston, Monroe, Oakland, Washtenaw, Wayne	9,773.78
482	Wayne	5,517.25
484	Genesee, Huron, Lapeer, Oakland, Sanilac	6,395.88
485	Genesee	2,776.38
486	Arenac, Clare, Gladwin, Midland, Ogemaw, Oscoda, Roscommon, Saginaw	2,035.29
487	Alcona, Bay, Iosco, Tuscola	5,958.33
488	Clinton, Eaton, Gratiot, Ingham, Ionia, Isabella, Livingston, Shiawassee	4,604.17
489	Ingham	2,337.35
490	Allegan, Barry, Branch, Calhoun, Cass, Kalamazoo, St. Joseph, Van Buren	9,942.10
491	Berrien	- 0 -

continued on page 28



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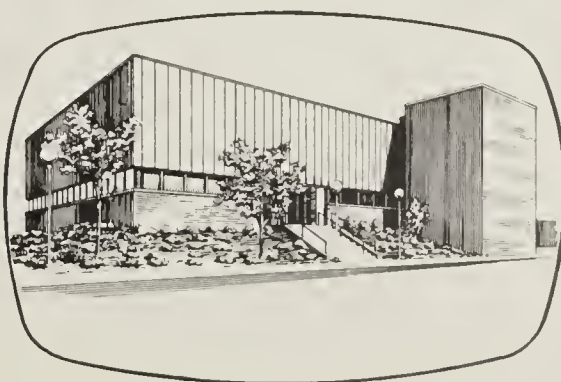
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TABLE IV/Continued

492	Calhoun, Hillsdale, Ingham, Jackson, Lenawee	7,052.27
493	Kent, Lake, Mecosta, Montcalm	797.42
494	Mason, Muskegon, Newaygo, Oceana, Ottawa	1,471.90
495	Kent	14,269.48
496	Antrim, Benzie, Grand Traverse, Kalkaska, Leelanau, Manistee, Missaukee, Osceola, Wexford	20,369.10
497	Alpena, Charlevoix, Cheboygan, Chippewa, Crawford, Emmett, Luce, Mackinac, Montmorency, Otsego, Presque Isle	17,508.33
498	Alger, Delta, Dickinson, Marquette, Menominee, Schoolcraft	1,253.75
499	Baraga, Gogebic, Houghton, Iron, Keweenaw, Ontonagon	6,125.00

VIII. When claim was settled

- A. Settled/Abandoned — 318
- B. Court or Dismissed — 191
- C. Arbitration — 4

IX. When claim was settled after legal proceedings commenced

- A. Before filing — 296
- B. Before hearing — 289
- C. During trial — 21

D. After trial/before decision — 24

E. After trial/before appeal — 143

F. During appeal — 0

G. After appeal — 3

H. Abandoned — 34

I. Arbitration — 1

E. Contraindicated — 27

F. More appropriate alternative — 95

G. Delayed — 46

H. Improperly performed — 179

I. Not performed — 23

J. Misdiagnosed caused — 108

K. Inadequate assessment — 40

Characteristics of incident causing claim

I. Severity of injury

- A. Emotional only — 6.1%
- B. Temporary disability — 44.0%
- C. Permanent injury — 28.1%
- D. Death — 20.9%

II. Place of injury

- A. Hospital inpatient — 68.1%
- B. Emergency room — 11.6%
- C. Hospital outpatient — 3%
- D. Nursing home — < 1%
- E. Doctor's office — 14.8%
- F. Patient's home — < 1%
- G. Other outpatient facility — 1%
- H. Other — 1%

III. Location where injury occurred in hospital

- A. Patient room — 17.2%
- B. Labor and delivery — 9.1%
- C. Operating room — 53.2%
- D. Recovery — .6%
- E. Critical care unit — 3.6%
- F. Special procedures room — 14.1%
- G. Nursery — .8%
- H. Radiology — 1.4%

IV. Reason for alleged injury

- A. Diagnosis delayed — 103
- B. Failure to diagnose — 130
- C. Wrong diagnosis — 33
- D. Treatment unnecessary or not indicated — 151

V. Others contributing to injury — (See Table V.)

This data is presented as preliminary findings of the survey. Future articles will analyze trends in the area of malpractice litigation in order to determine possible areas needing to be addressed either through legislation or medical education.

The bureau would like to thank the Michigan insurance commissioner and the Department of Licensing and Regulation for their assistance.

TABLE V

Others contributing to injury

Attending Physician	180
House Staff	79
Consultant	4
RN	24
LPN	6
Aid	0
Orderly	1
Pharmacist	1
Radiologist	8
Radiological Technician	4
Anesthesiologist	2
Anesthetist	1
Pathologist	4
Lab Technician	1
Physician Assistant	6
Physical Therapist	1
Maintenance Personnel	1
Others	16
Patient	9

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HEALTH PLANNING UPDATE

By **Dennis Paradis, Director**
MSMS Physician/HSA Support Center

The hospital bed reduction program began in 1977 when a coalition composed of the Big Three Auto Companies, organized labor and BC/BSM was asked by the legislature to suggest ways to lower Medicaid costs. The coalition proposed the elimination of unnecessary hospital beds as an activity that would result in large savings of health care dollars.

Legislation was drafted which empowered the Michigan Department of Public Health to identify excess hospital beds and to take action through the Certificate of Need Program. A major political battle was waged to amend the legislation so that the determination of which hospital beds were to be eliminated was

made by the HSA. The legislation passed in this form as a part of PA 368 of 1978 (Public Health Code).

Following another political skirmish over the development of criteria and guidelines to guide the planning process for bed reduction, the task of planning which hospital beds to eliminate fell to the HSA. The HSAs had 210 days to develop a five-year plan on how to eliminate the excess hospital beds in their area. The deadline for submission to the Statewide Health Coordinating Council (SHCC) was Dec. 21. The SHCC has 120 days to approve or modify the six hospital bed reduction plans (the HSAs in Petoskey and Marquette have no excess hospital beds).

MSMS acknowledges there are excess hospital beds in Michigan. Because a cost savings through the reduction of excess hospital beds is theoretically possible, the MSMS has not opposed the bed reduction program. The benefits or detriments of the hospital bed reduction program will depend on the plan developed by each HSA. MSMS will not support any plan which is detrimental to the health care delivery system. The MSMS commitment to cost containment will not be extended to support any activity that does not promote a good health care delivery system.

On Jan. 23, the MSMS Council will be reviewing physician recommendations on the six bed reduction plans.



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CATEGORY I COURSES

Michigan Medicine each month carries a list of opportunities in Michigan for doctors of medicine to obtain Category I credit toward meeting the requirements of Michigan law. Sponsors of Category I programs and courses in Michigan are invited to submit information for the monthly calendar.

Each listing below, of programs that carry at least 3 hours of Category I credit, indicates a contact person, so the physician can obtain details. Physicians with questions about accredited programs may phone MSMS Headquarters, 517/337-1351.

Date: Jan. 9, 16, 23 & 30, 1980, **Liaison Psychiatry.** **Location:** Fisher Auditorium, Providence Hospital, Southfield. **Sponsor:** Providence Hospital, Sinai Hospital of Detroit and the Michigan Psychiatric Society. **For:** Psychiatrists. **Cost:** \$25. **Contact:** Daniel Schwartz, Dept. of Psychiatry, Sinai Hospital of Detroit, 6767 West Outer Dr., Detroit 48235. **Approved for:** 6 hours of Category I Credit.

Date: Jan. 16, 1980, **Hypertension.** **Location:** Saint John Hospital. **Sponsor:** CME Committee of Saint John Hospital. **For:** All interested physicians. **Cost:** \$90. **Contact:** Ms. Linda Radu, Secretary, Continuing Medical Education, Department of Health Education, Saint John Hospital, 22101 Moross Road, Detroit 48236. (313/343-4000). **Approved for:** 8 hours of Category I credit.

Date: Jan. 23-25, **Ford Hospital Sponsors MSOG, Michigan Society of Obstetricians and Gynecologists.** **Location:** Sugar Loaf. **Sponsor:** Henry Ford Hospital. **For:** Obstetricians and Gynecologists. **Contact:** Bruce H. Druckker, MD, Department of Obstetrics & Gynecology, Henry Ford Hospital, Detroit, 48202. 313/876-2464. **Approved for:** 8 hours of Category I Credit.

Date: Jan. 26, **External Fixation of Extremities.** **Location:** Education and Research Center, Henry Ford Hospital. **Sponsor:** Henry Ford Hospital. **For:** All interested physicians. **Cost:** \$70. **Contact:** Medical Education, Henry Ford Hospital, 2799 W. Grand Blvd., Detroit, 48202 (313) 876-1464. **Approved for:** 7 hours of Category I Credit.

Date: Jan. 30, **Cardiology: Spectrum Review.** **Location:** E. W. Sparrow Hospital, Lansing. **Sponsor:** E. W. Sparrow Hospital Dept. of Family Practice. **For:** All interested physicians. **Contact:** Jean Machtel, CME Coordinator, Sparrow Hospital, Lansing 517/487-2790. **Approved for:** 4 hours of Category I Credit.

Date: Feb. 3-8, 1980, **Midwinter Family Practice Update.** **Location:** Boyne Highlands, Harbor Springs. **Sponsor:** U-M Office of Continuing Education. **For:** All interested physicians. **Cost:** \$200. **Contact:** Towsley Center for CME, 313/764-2287. **Approved for:** 20 hours of Category I Credit.

Date: Feb. 9, **New Approaches to Common Clinical Microbiology Problems.** **Location:** Henry Ford Hospital. **Sponsor:** Michigan Society of Pathologists. **For:** Pathologists. **Contact:** T. A. Reyman, MD, Department of Pathology, Mt. Carmel Mercy Hospital, 6071 W. Outer Dr., Detroit, 48202. **Approved for:** 3 hours of Category I Credit.

Date: Feb. 9, 1980, **New Approaches to Common Problems in Clinical Microbiology.** **Location:** Henry Ford Hospital, Detroit. **Sponsor:** The Michigan Society of Pathologists. **For:** All interested physicians. **Contact:** T. A. Reyman, MD, Department of Pathology, Mt. Carmel Mercy Hospital, Detroit, 48235. **Approved for:** 3 hours of Category I Credit.

The following have been accredited directly by the AMA or by MSMS CME Accrediting Committee. Physicians may wish to write to the hospitals and organizations that are accredited and ask to be placed on mailing lists for announcements about future programs.

Organizations:

American Association for Hand Surgery, Warren
American College of Emergency Physicians, Lansing
American College of Psychiatrists, Southfield
American Society of Colon and Rectal Surgeons, Detroit
American Society of Dermatopathology, Ann Arbor
Ann Arbor Psychiatric Association
Commission Professional and Hospital Activities, Ann Arbor
Michigan Academy of Family Physicians
Michigan Academy of Plastic Surgery
Michigan State Medical Society
Michigan State University College of Human Medicine, East Lansing
Michigan Chapter, American Academy of Pediatrics
Michigan Dermatological Society
Michigan Heart Association
Michigan Lung Association, Lansing
Michigan Ophthalmological Society
Michigan Psychoanalytic Society
Michigan Society of Anesthesiologists
Noah Worcester Dermatological Society, Detroit
Section of Gastroenterology, American Society for Gastroenterology, Detroit
University of Michigan Medical Center, Ann Arbor
University of Michigan School of Public Health
Wayne State University School of Medicine, Detroit

Hospitals:

Bay County Medical Education (Bay Medical Center, Bay Osteopathic Hospital, Bay City Samaritan Hospital)
William Beaumont Hospital, Royal Oak
Beyer Memorial Hospital, Ypsilanti
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Burns Clinic Med. Center, PC/Northern Michigan Hospitals Inc., Petoskey
Butterworth Hospital, Grand Rapids
Central Michigan Community Hospital, Mt. Pleasant
Chippewa County War Memorial Hospital, Sault Ste. Marie

Community Health Center of Branch County, Coldwater
Community Hospital Association of Battle Creek
Cottage Hospital of Grosse Pointe
Detroit-Macomb Hospital Association
Dickinson County Memorial Hospital, Iron Mountain
Ferguson-Droste-Ferguson Hospital, Grand Rapids
Grace Hospital, Detroit
Gratiot Community Hospitals, Alma
Hawthorn Center, Northville
Henry Ford Hospital, Detroit
Heritage Hospital, Taylor
Holy Cross Hospital, Detroit
Hurley Medical Center, Flint
Ingham Medical Center, Lansing
Kalamazoo Regional Psychiatric Hospital
Lakeshore Continuing Medical Education, Inc. (Hackley Hospital and Mercy Hospital, Muskegon)
Leila Y. Post Montgomery Hospital, Battle Creek
Marquette General Hospital
McLaren General Hospital, Flint
Mecosta County General Hospital, Big Rapids
Mercy Hospital, Port Huron
Metropolitan Regional Psychiatric Hospital
Michigan Psychoanalytic Institute, Southfield
Midland Hospital Center
Mt. Carmel Mercy Hospital & Med. Center, Detroit
Munson Medical Center, Traverse City
North Detroit General Hospital, Detroit
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Orthopedic Guild, Inc., St. Joseph
Pennock Hospital, Hastings
Pontiac General Hospital, Pontiac
Portage View Hospital, Hancock
Port Huron Hospital CME Committee
Providence Hospital, Saginaw
Saginaw Cooperative Hospitals, Inc., Saginaw
Southwestern Michigan Area Health Education Center (Bronson Hospital and Borgess Hospital), Kalamazoo
St. Francis Hospital, Escanaba
St. John Hospital, Detroit
St. Joseph Hospital, Flint
St. Joseph Mercy Hospital, Pontiac
St. Joseph Mercy Hospital, Ann Arbor
St. Lawrence Hospital, Lansing
St. Mary's Hospital, Grand Rapids
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Sinai Hospital of Detroit, Detroit
Southwest Detroit Hospital
Edward Sparrow Hospital, Lansing
Traverse City Regional Psychiatric Hospital, Traverse City
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West Shore Consortium, CME, Ludington/Hart/Manistee
Ypsilanti Regional Psychiatric Hospital, Ypsilanti

continued on page 34

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CATEGORY I COURSES/continued

Date: Feb. 9-16, 1980, **Infectious Diseases Today.** **Location:** Aboard tss Festivale in the Caribbean. **Sponsor:** Wayne State University School of Medicine, Div. of CME. **For:** All interested physicians. **Contact:** Wayne State University School of Medicine, Division of Continuing Medical Education, 1206 Scott Hall, Detroit, MI 48201 (313) 577-1180. **Approved for:** 36 hours of Category I Credit.

Date: Feb. 13, 20, 27 and March 5, 12 & 19, 1980, **Child Development.** **Location:** Auditorium, Mount Carmel Mercy Hospital, Detroit. **Sponsor:** Mt. Carmel Mercy Hospital, Sinai Hospital of Detroit and the Michigan Psychiatric Society. **For:** Psychiatrists. **Cost:** \$25. **Contact:** Daniel Schwartz, Dept. of Psychiatry, Sinai Hospital of Detroit, 6767 West Outer Dr., 48235. **Approved for:** 9 hours of Category I Credit.

Date: Feb. 18-22, 1980, **Emergency Medicine.** **Location:** Towsley Center, Ann Arbor. **Sponsor:** U-M Office of Continuing Medical Education. **For:** Emergency physicians, Family physicians, Internists, EMT's. **Cost:** \$275. **Contact:** Towsley Center for CME, 313/764-2287. **Approved for:** 36½ hours of Category I Credit.

Date: Feb. 21, "Antenatal Assessment of Fetal Well-Being." **Location:** Edward W. Sparrow Hospital, Lansing. **Sponsor:** Michigan Society of Obstetricians and Gynecologists and Michigan Section, American College of Obstetricians and Gynecologists. **For:** Obstetricians and Gynecologists. **Cost:** \$3 luncheon charge. **Contact:** Richard W. Pomeroy, MD, (517) 487-2511. **Approved for:** 4 hours of Category I Credit.

Date: Feb. 22-24, 1980, **Mid-Winter Meeting.** **Location:** Hospitality Inn, Lansing. **Sponsor:** Michigan Academy of Family Physicians. **For:** Family physicians. **Cost:** \$85. **Contact:** Michigan Academy of Family Physicians, 416 North Homer, Suite #107, Lansing, MI 48912. **Approved for:** 14 hours of Category I Credit.

Date: Feb. 25, 26, 28 and March 1, **Advanced Cardiac Life Support.** **Location:** Education and Research Center, Henry Ford Hospital. **Sponsor:** Henry Ford Hospital. **For:** All interested physicians. **Cost:** \$175. **Contact:** Medical Education, Henry Ford Hospital, 2799 W. Grand Blvd., Detroit, 48202 (313) 876-1464. **Approved for:** 20 hours of Category I Credit.

Date: March 10-14, **Diagnostic Radiology: Practical Approaches to Common Problems.** **Location:** Northstar, Lake Tahoe. **Sponsor:** Oakland Hospital. **Co-Sponsor:** American College of Radiology. **For:** All interested physicians. **Cost:** \$300. **Contact:** Alan T. Hennessey, MD, or Joyce Esper, 313-336-3000, ext. 236. **Approved for:** 30 hours of Category I Credit.

Date: March 15, **Genetic Disease in Clinical Practice.** **Location:** Education and Research Center, Henry Ford Hospital. **Sponsor:** Henry Ford Hospital. **For:** All interested physicians. **Cost:** \$70. **Contact:** Medical Education, Henry Ford Hospital, 2799 W. Grand Blvd., Detroit, (313) 876-1464. **Approved for:** 7 hours of Category I Credit.

Date: March 19-21, 1980, **Advances in Pediatrics.** **Location:** Towsley Center, Ann Arbor. **Sponsor:** U-M Office of Continuing Medical Education. **For:** All interested physicians. **Cost:** \$190. **Contact:** Towsley Center for CME, 313/764-2287. **Approved for:** 21 hours of Category I Credit.

Date: March 19, 1980, **Infectious Diseases in Obstetrics and Gynecology.** **Location:** Saint John Hospital. **Sponsor:** CME Committee of Saint John Hospital. **For:** All interested physicians. **Cost:** \$90. **Contact:** Ms. Linda Radu, Sec-

retary, Continuing Medical Education, Department of Health Education, Saint John Hospital, 22101 Moross Road, Detroit 48236 (313/343-4000). **Approved for:** 8 hours of Category I Credit.

Date: March 22, **Radiation Therapy in Everyday Clinical Practice.** **Location:** Education and Research Center, Henry Ford Hospital. **Sponsor:** Henry Ford Hospital. **For:** All interested physicians. **Cost:** \$55. **Contact:** Medical Education, Henry Ford Hospital, 2799 W. Grand Blvd., Detroit, 48202 (313) 876-1464. **Approved for:** 5½ hours of Category I Credit.

Date: March 26, **Placental Pathology — Clinical Applications.** **Location:** Michigan Inn, Southfield. **Sponsor:** Michigan Society of Obstetricians and Gynecologists and Michigan Section, American College of Obstetricians and Gynecologists. **For:** Obstetricians and Gynecologists. **Contact:** Don R. Krohn, MD, Dept. of OB/GYN, Providence Hospital, Southfield, (313) 424-3000. **Approved for:** 7 hours of Category I Credit.

Date: March 26-28, 1980, **Urology Conference.** **Location:** Towsley Center, Ann Arbor. **Sponsor:** U-M Office of Continuing Medical Education. **For:** All interested physicians. **Cost:** \$175. **Contact:** Towsley Center for CME, 313/764-2287. **Approved for:** 21 hours of Category I Credit.

Date: March 27-April 2, 1980, **MAFP and SCAFP "Ails of Summer" Meeting.** **Location:** Kiawah Island, Charleston, SC. **Sponsor:** Michigan Academy of Family Physicians and South Carolina Academy of Family Physicians. **For:** Family physicians. **Cost:** \$100. **Contact:** Michigan Academy of Family Physicians, 416 North Homer, Suite #107, Lansing, MI 48912. **Approved for:** 25 hours of Category I Credit.

Date: March 29, 1980, **Gastroenterology for the Family Physician.** **Location:** Towsley Center, Ann Arbor. **Sponsor:** U-M Office of Continuing Medical Education. **For:** All interested physicians. **Contact:** Towsley Center for CME, 313/764-2287. **Approved for:** 7 hours of Category I Credit.

Date: April 10-11, **General Surgery.** **Location:** Towsley Center, Ann Arbor. **Sponsor:** U-M Office of Continuing Medical Education. **For:** All interested physicians. **Cost:** \$160. **Contact:** Towsley Center for CME, 313/764-2287. **Approved for:** 14 hours of Category I Credit.

Date: April 10-11, **Symposium on Gastrointestinal Hemorrhage.** **Location:** Towsley Center, Ann Arbor. **Sponsor:** U-M Office of Continuing Medical Education. **For:** General Surgeons, gastroenterologists, internists, family physicians and radiologists. **Cost:** \$190. **Contact:** Towsley Center, Office of CME, 313/764-2287. **Approved for:** 16 hours of Category I Credit.

Date: April 14-18, **Family Practice Review.** **Location:** Towsley Center, Ann Arbor. **Sponsor:** U-M Office of Continuing Medical Education. **For:** All interested physicians. **Cost:** \$275. **Contact:** Towsley Center for CME, 313/764-2287. **Approved for:** 33 hours of Category I Credit.

Date: April 23-25, **Hematology Review.** **Location:** Towsley Center, Ann Arbor. **Sponsor:** U-M Office of Continuing Medical Education. **For:** Hematologists, Medical Technologists. **Cost:** \$190. **Contact:** Towsley Center for CME, 313/764-2287. **Approved for:** 24 hours of Category I Credit.

Date: April 28-30, **Ob-Gyn Conference.** **Location:** Towsley Center, Ann Arbor. **Sponsor:** U-M Office of Continuing Medical Education. **For:** All interested physicians. **Cost:** \$175. **Contact:** Towsley Center for CME, 313/764-2287. **Approved for:** 21 hours of Category I Credit.

Date: April 30, **Hypertension: Evaluation and Treatment.** **Location:** Towsley Center, Ann Arbor. **Sponsor:** U-M Office of Continuing Medical

Education. **For:** All interested physicians. **Cost:** \$65. **Contact:** Towsley Center for CME, 313/764-2287. **Approved for:** 7 hours of Category I Credit.

Date: May 2-3, 1980, **Nuclear Radiology Workshop.** **Location:** Towsley Center, Ann Arbor. **Sponsor:** U-M Office of Continuing Medical Education. **For:** All interested physicians. **Cost:** \$150. **Contact:** Floyd C. Pennington, Director, Office of Continuing Medical Education, Towsley Center, University of Michigan Medical School, Ann Arbor 48109. **Approved for:** 16 hours of Category I Credit.

Date: May 10, **Pulmonary Pathology and Transbronchial Biopsy.** **Location:** Borgess Hospital, Kalamazoo. **Sponsor:** Michigan Society of Pathologists. **For:** Pathologists. **Contact:** T. A. Reyman, MD, Department of Pathology, Mt. Carmel Mercy Hospital, 6071 W. Outer Dr., Detroit 48202. **Approved for:** 3 hours of Category I Credit.

Date: May 21, 1980, **Medical Therapy in Family Practice.** **Location:** Saint John Hospital. **Sponsor:** CME Committee of Saint John Hospital. **For:** All interested physicians. **Cost:** \$90. **Contact:** Ms. Linda Radu, Secretary, Continuing Medical Education, Department of Health Education, Saint John Hospital, 22101 Moross Road, Detroit 48236 (313/343-4000). **Approved for:** 8 hours of Category I Credit.

Date: July 25-27, 1980, **EKG Interpretation and Arrhythmia Management.** **Location:** Grand Hotel, Mackinac Island. **Sponsor:** International Medical Education Corporation. **For:** All interested physicians. **Cost:** \$215.00. **Contact:** International Medical Education Corporation, Division of Postgraduate Education, Dept. 12, 64 Inverness Drive East, Englewood, CO 80112 (800) 525-8646 Toll Free or (313) 773-1144. **Approved for:** 15 hours of Category I Credit.

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DESCRIPTION: Methyltestosterone is 17^β-Hydroxy-17-Methylandrosta-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunuchism 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency 4. Post-puberal cryptorchidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric,

avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE**

REACTIONS: Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. In the male: Eunuchoidism and eunuchism, 10 to 40 mg; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg; Postpuberal cryptorchism, 30 mg. **REFERENCE:** R. B. Greenblatt, M.D.; R. Witherington, M.D.; I. B. Sipahioglu, M.D.; Hormones for Improved Sexuality in the Male and the Female Climacteric. *Drug Therapy*, Sept. 1976. **SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only

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Michigan's government and you, doctor

The Michigan Department of Public Health

**By Dennis Paradis, Sherry Wellman
MSMS Department of Government Relations**

Part two of a series to help Michigan physicians better understand how government affects the practice of medicine.

Physicians are well acquainted with the traditional role of public health departments in the eradication of communicable diseases. The Michigan Department of Public Health, which was created in 1873, still performs necessary services relating to communicable disease.

But as the scope of health care problems has expanded over the years, so has the focus of the MDPH. Today the MDPH provides traditional public health services in immunizations and venereal disease; ranges through health care delivery issues, such as HMOs and certificates of need, and extends to toxic substance disposal and radiological health problems.

The Legislature recently gave the Michigan Department of Public Health a new tool to deal with developing health issues. The passage of the Public Health Code (PA 368 of 1978) represents a codification of public health statutes passed in the last century. The five year effort that resulted in the Public Health Code provided the opportunity to repeal obsolete legislation, permitted an overview of the interaction of health programs and developed mechanisms to deal with coming health care issues.

The director of the Michigan Department of Public Health is Maurice

Reizen, MD. Doctor Reizen is appointed by the Governor to carry out the goals of the department: The protection and promotion of health. To this end, the director has very broad powers in times of public health emergencies and natural disasters. The director is aided by the Public Health Advisory Council, which also is appointed by the Governor.

A brief overview of the organizational structure of MDPH will provide a better understanding of the various areas of involvement.

Central Services —

Theodore Ervin, Deputy Director

This unit performs budget, personnel, finance and informational services for MDPH. Additionally, this unit houses the section on Vital and Health Statistics. This is the point of origin for much of the health statistics and epidemiological data which permit an overview of Michigan's health status.

Physicians' reports of the incidence of communicable diseases are included in data released by this section.

Bureau of Disease Control and Laboratory Services —

Kenneth Wilcox, MD, Bureau Chief

This bureau is responsible for two distinct functions.

The first is a continuous surveillance and epidemiological study of disease. This includes communicable diseases such as measles, influenza and rabies, as well as non-communicable health problems such

as contamination by toxic substances. There are programs developed for the early detection, surveillance or prevention of disease, such as venereal disease, renal disease, tuberculosis, hypertension and cervical cancer.

The second function of the bureau concerns laboratory services, and originated when the Legislature authorized a state health laboratory in 1907.

The MDPH laboratory provides diagnostic services for bacterial, viral, mycotic, parasitic and certain organic diseases.

The department's virology laboratory is the only such diagnostic service open to all Michigan physicians and furnishes free rabies diagnostic services.

The MDPH laboratory provides a wide range of biological products. Products for the detection, prevention and treatment of communicable diseases are provided free of charge to private physicians.

The laboratory provides blood derivatives from the outdated blood donated from blood banks. The Bureau also has a program to develop antibiotic substances specific for malignant tumors and a program for the licensing and inspection of clinical laboratories.

Bureau of Personal Health Services —

Gerald Rice, MD, Bureau Chief

This bureau houses several programs and services that focus on specific categories of 'high risk' persons. Physicians' private services are aug-

mented by MDPH programs provided in child health, maternal and infant health, family planning, crippled children and migrant health. There is also a section on special health projects that focuses on issues such as rural and urban health care and native American health problems. These programs and services are designed to identify and assist persons with special health needs.

Bureau of Health Care Administration —

Hermann Ziel, MD, Bureau Chief

This bureau houses the regulatory arm of the department.

The division of *Health Facility Licensing and Certification* is designed to assure that health facilities (hospitals and nursing homes, etc.) continue to meet licensure and Medicaid/Medicare standards. This includes aspects of the physical plant, nursing services, dietary services, administrative and clerical operations and medical records.

The division of *Health Facility Planning and Construction* is the state agency responsible for certificate of need review. This gives the MDPH a considerable voice in the expansion of institutional health services. This bureau also houses the licensing mechanisms for emergency medical services and health maintenance organizations.

Bureau of Environmental and Occupational Health —

Lee Jager, Bureau Chief

This bureau maintains surveil-

lance over the locations where health problems may develop. It focuses on mobile home and campground sites, rodent control, agricultural labor camps, food service sanitation, drinking water supplies and swimming pools. The occupational health component of this bureau identifies health hazards in the work place such as excessive noise, poor lighting, fumes, gasses, dust and radiation.

Other areas

In addition to the bureaus of the MDPH, there are two offices that deserve physicians' awareness.

The Office of Substance Abuse Services is an independent office attached to the MDPH for budgetary purposes. The Office of Substance Abuse Services carries out four programs which relate to the abuse of alcohol and drugs: rehabilitation and treatment; licensing of substance abuse programs; education and training; and research, planning and evaluation.

The Office of Local Health Services is newly-created and designed to improve the interaction between the MDPH and the 48 local health departments. The passage of the Public Health Code has necessitated a close cooperation between state and local health departments. The Office of Local Health Services is intended to be the liaison between these levels of government.

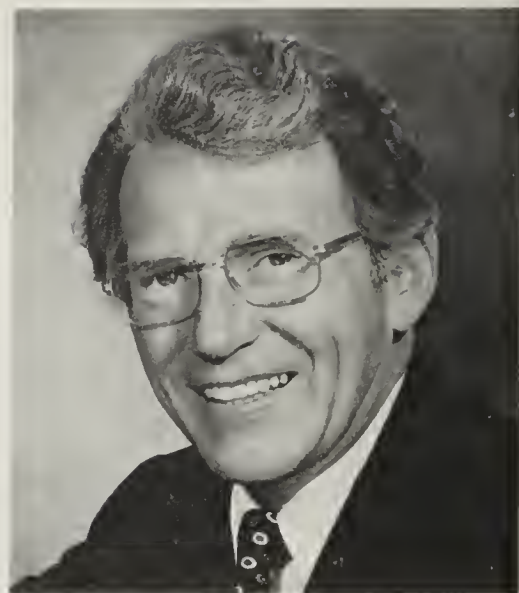
The Michigan State Medical Society maintains a liaison with MDPH at several levels. The MSMS Public

Health Liaison Committee has recently been formed in recognition of the growing interrelationship between medicine and public health. Richard Gascoigne, MD, Adrian, chairs this committee. The Steering Committee on Health Planning which is chaired by Kenneth Ray, MD, Trenton, also has a direct interest in MDPH. The Certificate of Need program, which is the regulatory 'stick' in the health planning mechanism is housed in the department. A subcommittee of the Steering Committee on Health Planning is the Ad Hoc Committee on EMS categorization. This ad hoc committee was created to bring physician experts on emergency medical services together to provide input to the MDPH on the categorization of hospital emergency rooms. The ad hoc committee is chaired by Brooker Masters, MD, Baldwin.

The MDPH has been in existence for over 100 years. It boasts of a long list of achievements and has assumed a role of national leadership on several occasions. The MDPH is a valuable ally to the practicing physician in the protection and promotion of the health of Michigan citizens.

Lt. Governor: Mistake for government to be too involved in health care

By Willah Weddon, special to Michigan Medicine



Lt. Gov. Brickley

"I always have been vigorously opposed to nationalization of health services," Lt. Governor James H. Brickley said at the outset of an interview in his office on the first floor of the capitol building in Lansing.

Brickley returned to the Lt. Governor's position in January 1978, following his four years as president of Eastern Michigan University.

His basic concept that government should provide only those services people cannot provide for themselves, has remained constant.

"It would be a terrible mistake for government to get over-involved in the delivery of health care services," he says.

"Government always will be obligated to see that basic health care is provided, but that doesn't mean the government should take it over," he continues, "just as it is one thing to see people don't starve, and another to take over the food industry.

Candid comments

"When I look at the opinion polls, I see people always rank medicine and doctors at the top or close to it," he says candidly. "And I notice they rank government and politicians at the bottom. I've always thought it didn't make a lot of sense to give the most reputable institution to one considered most disreputable."

He would like to see politicians' public image improve, of course, and has acquired a personal reputation among colleagues and members of the news media for his forthrightness and honesty.

As Lt. Governor Mr. Brickley has not had to deal directly with many issues in the medical field. It is generally conceded, however, that he is in line for the nomination as the next Republican gubernatorial candidate. In this capacity his views should be given serious consideration now.

"My guess is that as we move toward broader insurance there will be fewer people who are not covered, so the pressures for nationalization will become less," he says. "On the other hand, the more insurance coverage there is, the more costs go up. Just as with automobile insurance, people who have it may be less careful."

As the number of people with third party health care payors increases, there is less incentive to use restraint, he believes.

"We have to build into our medical care delivery system incentives for restraint . . . without it there is an insatiable demand," he continues.

"For example, there are some people who would see a physician every day if possible and I'm told that some studies have intimated as many as one-half the cases are considered to be psychosomatic.

"If this is the case, we could so abuse our medical system it could collapse and break the country financially."

Brickley points out that if health care costs continue to increase as rapidly as they have this year, which is more than double the rate the Headlee amendment permits state

expenditures to grow, something will have to give down the line. With the Headlee amendment, the state's revenues will not grow fast enough to keep up with Medicaid increases alone.

If costs cannot be stabilized, he anticipates there may be heightened efforts by the state to "artificially and arbitrarily" regulate the sources of the cost increases. "This possibility of increasing governmental interference in health care is not one which I personally look forward to," he says.

"I hope the medical profession will continue to play a positive role in cost containment," he emphasizes. He is particularly concerned with the Detroit Metropolitan area where vacant hospital beds have increased costs. "Wayne County General Hospital has only about 40 percent occupancy, Detroit City General is only partially occupied and the new Detroit Hospital is over-bedded before it's opened."

Broad view

"I don't know what the final answer is. But it is in the interest of the medical profession to look at the problem broadly rather than identifying with individual hospitals," he says.

Fifty year-old Brickley, holding a law degree from the University of Detroit and a master's degree in public and administrative law from New York University, has served as a special agent with the FBI, on the Detroit Common Council, as chief assistant prosecutor of Wayne County and a U.S. Attorney for Eastern Michigan.

He was first elected lieutenant governor in 1970 and did not seek re-election in 1974. After serving as EMU president, however, he returned to the political arena in 1978 as Governor William G. Milliken's running-mate. Although he enjoyed the academic world, he says he missed the life in government where he has always worked closely with Milliken.

Brickley has become convinced the growth of government has resulted in near political paralysis.

"The nationalization of public services over the past 40 years, the building of bigger and more unwieldy bureaucracies in Washington ... has proven to be an ineffective and inefficient substitute for local government.

"The economy, the simplicity and the accountability of local control cannot be matched by either the state or federal governments," he insists firmly.

Western Michigan Physician Advisory Committee Formed

In an effort to promote greater constructive physician involvement in the health planning process of the West Michigan Health Systems Agency, the Steering Committee of the West Michigan Physician Advisory Committee (WMPAC) has been created to:

- Discuss health planning issues
- Provide medical consultation to the WMHSA
- Receive and disseminate health planning information to appropriate physicians and specialty societies
- Provide direction to and receive information from physician health planning task forces

Ted VanderVeen, MD, is chairman of the advisory committee, with Carl Kubek, DO, as chairman-elect and John P. Papp, MD, treasurer.

The advisory committee has directed the MSMS Physician/HSA Support Center to establish a Physician Health Manpower Task Force to work with the West Michigan HSA on the study of primary ambulatory care. The study will be used as the basis for the Health Manpower Shortage Areas designation in the West-Central Michigan area.

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Over the past several months, infant formulas have been involved in an increasing number of health-related problems. Ranging from nutrient deficiencies to processing breakdowns, these events have served to focus attention on procedures necessary to assure the quality and safety of these products.

The Food and Drug Administration advises that all hospitals and other health facilities immediately begin to evaluate their procedures for storage, distribution, and preparation of infant formulas to identify possible points of contamination and/or reduction in nutritive value.

In addition, the FDA needs to have more information on infant illnesses in which formulas may be implicated. The agency would welcome information on the clinical nature of such illnesses, any supportive laboratory findings, the product or products that may be involved, the time that the problem occurred, and the length of time the formula was used. This information should be sent to FDA's Bureau of Foods, HFF-1, 200 C Street, S.W., Washington, D.C. 20204.

FDA is reevaluating its procedures for assuring the quality and nutritional efficacy of infant formulas. The agency is considering the establishment of standards for nutritional quality, as well as development of procedures for requiring premarket clearance of such formulas.

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Positions open

Family Practitioner wanted in Southeast Michigan to associate with a group of two physicians. Should have special training in ophthalmology. \$45,000 salary with 2 weeks vacation, paid malpractice insurance, 44 hour week. Contact — Heffron Clinic, 231 N. Main St., Adrian, MI 49221.

Henry Ford Hospital Fairlane Center is now accepting applications for the following professional staff additions in 1980: General Internal Medicine, Psychiatry, Dermatology, Emergency Room, Radiology, Obstetrics-Gynecology, Orthopaedics, Rheumatology, Pediatrics. We desire candidates who have a strong commitment to primary care objectives with or without teaching or research assignments. Please submit Curriculum Vitae to Wilmer M. Rutt, MD, Medical Director, Henry Ford Hospital Fairlane Center, 19401 Hubbard Drive, Dearborn, Michigan, 48126, or call collect at 313-336-2100 ext. 296.

Cardiologist Internist, 31, ABIM certified, University trained Invasive and Noninvasive Cardiology, seeks solo or associate position available July, 1980. Contact George B. Ghanem, MD, 39030 Pinebrook, Sterling Hgts, MI 48078. 313/979-2848.

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Internist And Pediatrician wanted for attractive practice in Central Michigan community. Ideal for couple. To join group of internists with subspecialty. Write with C.V. to: MSMS, Box 19, 120 W. Saginaw, East Lansing, MI 48823.

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Experienced General Surgeon needed to join two general internists, a gastroenterologist, four family practitioners and a pediatrician in a busy Satellite of the Marshfield Clinic at Ladysmith, Wisconsin. Complete details and personal interview will be arranged for qualified applicants. Send curriculum vitae, bibliography and three references to William M. Toyama, MD, Department of Surgery, Marshfield Clinic, 1000 N. Oak Avenue, Marshfield, Wisconsin 54449.

Positions Available psychiatric residents at the PGY-2 and PGY-3 level to augment a 36 position residency program starting as early as January of 1980. Inquiries should be directed to: Clifford C. Kuhn, MD, Director of Basic Residency Program, University of Louisville

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Disciplinary Actions . . . Michigan Board of Medicine

For months of September and October, 1979.

The following actions of the Michigan Board of Medicine were taken following investigation and appropriate administrative action, are printed from official memoranda to MSMS and are not editorialized:

Name & Address	Date & Action Taken	Reason
JORDAN, Franz, W., MD 337 A State Street Boyne City, MI License #026535 D.O.B.: 10-18-39	9-6-79 2 Year Probation	Mental or physical inability reasonably related to and adversely affecting the licensee's ability to practice in a safe and competent manner.
SUNDLING, Richard W., MD 10455 Red Barn Circle Chelsea, MI 48118 License #24848 D.O.B.: 8-15-35	Summarily Suspended	Substance abuse. Mental or physical inability reasonably related to and adversely affecting the licensee's ability to practice in a safe and competent manner. Obtaining, possessing, or attempting to obtain or possess a controlled substance without lawful authority; or selling, prescribing, giving away, or administering drugs for other than lawful diagnostic or therapeutic purposes.
SHAYA, Ezra, MD 31170 Hoover Warren, MI 48093 License #24088 D.O.B.: 6-30-25	10-13-78 Reprimand Probation 1 yr.	Departure from the terms of probation as set for in the Final Order. Probation extended until further order of the Board of Medicine
STRAUSS, Eugene C., MD Veterans Admin. Hospital Battle Creek, MI 49016 License #30040 D.O.B.: 11-19-13	10-11-79 Suspension until licensee submits to mental and physical exams	Mental or physical inability reasonably related to & adversely affecting the licensee's ability to practice in a safe and competent manner.



PRESIDENT'S PAGE

Do you know, Doctor, what goes on in your hospital?

By Ernest P. Griffin, Jr., MD, MSMS President

Do you know what goes on in your hospital?

Some of you may, but the records of the Michigan Physicians Mutual Liability Insurance Company indicate that many of you do not.

As you will see, hospital administration and medical staff decisions can have a very significant impact on the medical professional liability problem. It would appear that re-evaluation of some procedures and the institution of some new procedures is in order.

The complex machines that we use in our practice every day are often life-saving devices, but they introduce hazards. These dangers must be delineated and every safeguard used. Undetected hazards may maim or kill. Even the new model of the old reliable may be faulty.

Hazards

Let us consider some possible situations:

- The pencil cautery with the finger-tip switch that fits in the pocket of the patient's operating drape is a wonderful, handy device until it becomes soaked with fluid and begins to fry away. If it

Doctor Griffin serves as secretary-treasurer of the Michigan Physicians Mutual Liability Company.

is masked by other operating room noises, you may have a significant patient burn by the time you become aware of the smoke and odor of burning tissue.

- The emergency alarms on many of our life-support systems are crucial. Evaluation of the operations manual and the operating personnel are vital items. For instance, there is the emergency alarm with the manual silencing switch. Who has the responsibility for the re-set of the system? Is it internally powered, so that it is unaffected by power failures?

- Delineation of responsibility for the checking of repaired hospital equipment is necessary. Following repair or installation, if an anesthetic gas is delivered by the oxygen line, you may have a catastrophe before the problem is apparent.

- Do you assume that there is a satisfactory, reliable method of sponge, lap pad and instrument count in your hospital? This has been demonstrated not always to be true. There are hospitals in Michigan that have no counting procedure. A remote in-count and an on-the-scene outcount is not reliable. Counting the instruments while doing the clean-up does not prevent re-operation.

- And then there is the actual disbelief of the incorrect count, when we resort to the ra-

diograph for confirmation. Of course, X-ray opaque sponges are being used because the detail man stated their x-ray opacity is a fact. Have they been radiographed and do the staff surgeons and the radiologists have a visual record of the configuration of the X-ray opaque materials? After all, the opaque materials on, in, and under the patient will be recorded and we want to recognize the offender.

Committees

These few notes are to demonstrate that each and every hospital should either initiate or revitalize a Risk Management Committee. Hospital equipment and procedures should be evaluated by knowledgeable physicians. Such actions may save you time, reputation and money. Most importantly, you may save a patient's life or prevent irreparable damage.

ROCHE

For recurrent attacks of urinary tract infection in women

BactrimTM DS Double Strength Tablets

Each tablet contains 160 mg trimethoprim and 800 mg sulfamethoxazole.

Just one tablet b.i.d. for 10 to 14 days



- Action at urinary/vaginal/lower bowel sites helps eliminate reservoirs of infecting organisms
- Distinctive antibacterial action plus wide spectrum helps eradicate recurrent UTI
- Low incidence of bacterial resistance in community practice

- Convenient *b.i.d.* dosage provides day-and-night antibacterial control
- Contraindicated during pregnancy and the nursing period. During therapy, maintain adequate fluid intake; perform CBC's and urinalyses with microscopic examination.

Before prescribing, please consult complete product information, a summary of which follows:

Indications and Usage: For the treatment of urinary tract infections due to susceptible strains of the following organisms: *Escherichia coli*, *Klebsiella-Enterobacter*, *Proteus mirabilis*, *Proteus vulgaris*, *Proteus morganii*. It is recommended that initial episodes of uncomplicated urinary tract infections be treated with a single effective antibacterial agent rather than the combination. Note: The increasing frequency of resistant organisms limits the usefulness of all antibacterials, especially in these urinary tract infections.

Also for the treatment of documented *Pneumocystis carinii* pneumonitis. To date, this drug has been tested only in patients 9 months to 16 years of age who were immunosuppressed by cancer therapy.

The recommended quantitative disc susceptibility method (*Federal Register*, 37:20527-20529, 1972) may be used to estimate bacterial susceptibility to Bactrim. A laboratory report of "Susceptible to trimethoprim-sulfamethoxazole" indicates an infection likely to respond to Bactrim therapy. If infection is confined to the urine, "Intermediate susceptibility" also indicates a likely response. "Resistant" indicates that response is unlikely.

Contraindications: Hypersensitivity to trimethoprim or sulfonamides; pregnancy; nursing mothers; infants less than two months of age.

Warnings: Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia with purpura in elderly patients on certain diuretics, primarily thiazides. Sore throat, fever, pallor, purpura or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended; therapy should be discontinued if a significantly reduced count of any formed blood element is noted.

Precautions: Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function.

Adverse Reactions: All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. **Blood dyscrasias:** Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. **Allergic reactions:** Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. **Gastrointestinal reactions:** Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea and pancreatitis. **CNS reactions:** Headache,

peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. **Miscellaneous reactions:** Drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L. E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.

Dosage: Not recommended for infants less than two months of age.

Urinary Tract Infections: Usual adult dosage—1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 10-14 days.

Recommended dosage for children—8 mg/kg trimethoprim and 40 mg/kg sulfamethoxazole per 24 hours, in two divided doses for 10 days. A guide follows:

Children two months of age or older

Weight		Dose—every 12 hours	
lbs	kgs	Teaspoonfuls	Tablets
20	9	1 teasp. (5 ml)	½ tablet
40	18	2 teasp. (10 ml)	1 tablet
60	27	3 teasp. (15 ml)	1½ tablets
80	36	4 teasp. (20 ml)	2 tablets or 1 DS tablet

For patients with renal impairment:

Creatinine Clearance (ml/min)	Recommended Dosage Regimen
Above 30	Usual standard regimen
15-30	½ the usual regimen
Below 15	Use not recommended

***Pneumocystis carinii* pneumonitis:** Recommended dosage: 20 mg/kg trimethoprim and 100 mg/kg sulfamethoxazole per 24 hours in equal doses every 6 hours for 14 days. See complete product information for suggested children's dosage table.

Supplied: Double Strength (DS) tablets, each containing 160 mg trimethoprim and 800 mg sulfamethoxazole, bottles of 100; Tel-E-Dose[®] packages of 100. Tablets, each containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500; Tel-E-Dose[®] packages of 100; Prescription Paks of 40, available singly and in trays of 10. Oral suspension, containing in each teaspoonful (5 ml) the equivalent of 40 mg trimethoprim and 200 mg sulfamethoxazole, fruit-licorice flavored—bottles of 16 oz (1 pint).



Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

Please see back cover.

Her next

quire

the Bactrim™ 3-system counterattack



ROCHE

Bactrim has shown high clinical effectiveness in recurrent cystitis as a result of its wide spectrum and distinctive antimicrobial action in the urinary, vaginal and lower intestinal tracts.

The probability of recurrent urinary tract infection appears to be enhanced by the establishment of large numbers of *E. coli* or other urinary pathogens on the vaginal introitus. The trimethoprim component of

Bactrim diffuses into vaginal fluid in effective concentrations, thus combating migration of pathogens into the urethra.

Studies have shown that Bactrim acts against *Enterobacteriaceae* in the bowel without the emergence of resistant organisms. Thus, Bactrim reduces the risk of introital colonization by fecal uropathogens. It has *no* significant effect on other normal, necessary intestinal flora.

Bactrim fights uropathogens in the urinary tract/vaginal tract/lower intestinal tract

Please see reverse side for summary of product information.

FEB 14 1980

Breaking News for Michigan Doctors

MEDIGRAM

CAPSULES

DAVID SIEGEL, MD, LANSING, chairman of the MSMS Medicaid Liaison Committee, reported to the MSMS Council Jan. 23 that the legislature will be considering a supplemental appropriation to raise Medicaid fee screens by five percent for the remainder of the fiscal year. The governor's executive budget recommendations for fiscal year 1980-81 carry a physician fee screen increase of seven percent in the aggregate.

ROBERT D. COYE, MD, Wayne State University School of Medicine dean since 1972, has announced he will retire from that position in September. Dean Coye has made an early announcement to allow for a smooth transition to his successor. He came to Wayne from the University of Wisconsin in December 1971 and began duties as dean in January 1972. Wayne spokesmen believe Doctor Coye will take a year's sabbatical beginning in September before returning to teach in the medical school's pathology department.

Inside this issue . . .

is a registration form for the 1980 Michigan Conference on Maternal and Perinatal Health, planned March 5-6 at the Hyatt Regency Dearborn. Program details appear with the registration form. Interested physicians are urged to fill out the form and mail it today to MSMS headquarters.

MSMS Council highlights

At its Jan. 23 meeting, the MSMS Council:

1. Authorized appointment of a task force to draw up an MSMS position paper on the bed reduction issue. The task force is to present the paper to the Council March 5. (Please see related article on back page.)
2. Called on MSMS to actively assist the director of the Michigan Department of Public Health in achieving a legislative solution to the problem of radioactive waste material disposal by hospitals and universities.
3. Gave the MSMS Committee on State Legislation and Regulations and MSMS staff the responsibility of influencing the course of HB 4555, the bill to reform Blue Cross Blue Shield of Michigan. The state legislation committee is to work for:
 - A clear statement that per-case participation is permitted.
 - A reasonable, efficient appeals process for cost containment planning.
 - A clear limitation on the authority of the insurance commissioner to intervene in the day-to-day functioning of the corporation.
 - Opposing the current proposition for a full-time appeals commission with staff, in favor of a standby commission on call.
 - Clarifying the fiscal liability of physicians in the provision of services.
4. Authorized purchase of video-tape equipment for officer and leadership training sessions and other uses.
5. Called for MSMS to oppose SB 778, which would permit direct reimbursement by BCBSM to psychologists and other allied health professionals, and to oppose SB 881, which would separate osteopathic from allopathic hospitals under certificate of need system.

CREDIT CARD PAYMENT for physician office bills may become more common soon as doctors join a program being offered by the MSMS/Physician Service Group, Inc. The MSMS/PSG program offers physicians a group discount rate of 2.5% on payments made by credit card, half the rate paid by a single physician office which offers charge card options. A credit card system is drawing considerable interest currently as more and more physicians seek ways to cut billing costs and reduce uncollectable accounts. For complete details on the MSMS/PSG program call Meredith Fors at 517/337-1351

THE MICHIGAN ARBITRATION

Advisory Committee is recommending the legislature wait two years before formally evaluating the state's medical arbitration system. The advisory committee feels there is not sufficient data available for a joint review committee to study. The advisory committee further recommends the legislature wait until mid-1983 to consider statutory changes in the arbitration laws.

A Dec. 31 interim report of the arbitration advisory committee shows a total of 161 cases filed in the arbitration program's first four years. Thirteen of those cases have been settled, three for the patient and 10 for the physicians and/or hospitals named as defendants. Sixty percent of the cases were filed in Wayne-Oakland-Macomb counties. Seventeen percent of the cases named physicians only as defendants, 30% named hospitals only and 52% physicians and hospitals together.

Sports Medicine Conference set April 10 in Lansing

The 1980 MSMS Sports Medicine Conference will be held April 10 in Lansing. Edwin R. Guise, MD, Detroit, conference chairman, notes the program will feature sessions on problems and injuries related to swimming; tennis; jogging; women's athletics; and head, neck, and knee injuries of all sports. Also offered will be sessions on rehabilitation and weight training techniques. Featured clinicians include Joseph Godfrey, MD, Buffalo, and Robert Teitge, MD, Stanford University. Charles Zimont, MD, Constantine, is the chairman of the MSMS Committee on Sports Medicine which sponsors the annual event. Full details and a registration form will appear in the next issue of Medigram as well as in the March issue of Michigan Medicine.

Medical decision act stuck

HB 4058, the Medical Treatment Decision Act, failed Jan. 23 to secure the necessary six affirmative votes to report the bill from the House Public Health Committee to the full floor. The proposal, sponsored by Rep. David Hollister, (D) Lansing, would authorize an agent to participate in medical decisions when a patient is incapable. This marks the second time the bill has been brought to a vote in committee and failed to be reported out, rendering further action improbable. MSMS endorsed the bill pursuant to a 1978 House of Delegates resolution.

Governor, leading lawmakers set health legislation priorities

Annual policy messages by Gov. Milliken, House Speaker Bobby Crim and Senate Majority Leader William Faust have import for Michigan medicine. The Governor, in his State of the State message, set top priority on passing legislation to improve distribution of health care personnel to underserved areas, to develop hospice care, to initiate a hospital capital expenditures limitation through the State Health Plan, to consolidate all state activity on HMOs, and to increase substance abuse and mental health activity. He has called for a substantial increase in mental health funding.

Speaker Crim put health care costs at the top of his list, and called for a special joint legislative committee to recommend by the year's end "the best long-term approach to reduce the rate of inflation in health care." Sen. Faust called Blue Cross Blue Shield reform legislation his top health priority.

Here is the program for 1980 Michigan Conference on Maternal and Perinatal Health

The program is approved for 11 hours of CME Category I Credit, and accepted for 11 Prescribed Hours by the American Academy of Family Physicians.

Wednesday Morning, March 5

8:45 a.m. Ultrasonography — "Dynamic Imaging of the Developing Fetus in the Obstetrician's Office: Pro and Con" — Charles W. Hohler, II, MD, assistant professor, Maternal-Fetal Medicine Division, Department of Obstetrics and Gynecology, University of Southern California, Los Angeles

9:30 a.m. Sensors — "Non-invasive Monitoring and Investigation of the Newborn Infant" — Alistair G. S. Philip, MD, associate professor of pediatrics, University of Vermont, College of Medicine, and co-director, Vermont/New Hampshire Regional Perinatal Program, Burlington

10:45 a.m. Monitors — "Biophysical Fetal Monitoring" — Tom E. Barden, MD, professor of obstetrics and gynecology, University of Cincinnati Medical Center

11:30 a.m. Panel Discussion

Wednesday Afternoon, March 5

1:30 p.m. Immunology — "Bonding, Breast Feeding, and Bugs" — Alan E. Beer, MD, professor and chairman, Department of Obstetrics and Gynecology, University of Michigan Medical School

2:15 p.m. Viral Infections — "Herpes and Hepatitis" — John L. Sever, MD, chief, Infectious Diseases Branch, National Institute of Neurological Diseases and Stroke, National Institutes of Health, Bethesda, MD

3:15 p.m. Lactation — "Human Milk: Nature's Vaccine" — Alan E. Beer, MD

4 p.m. Bacterial Infections — "Serious Infections in Obstetrics and Gynecology" — Rudolph P. Galask, MD, professor of obstetrics and gynecology and professor of microbiology, University of Iowa Hospitals

Thursday Morning, March 6

8:45 a.m. Applied Anesthesiology — "Anesthesia for Low-Risk Obstetrics: A Clinical Review" — Edward G. Bartholomew, MD, assistant professor, Wayne State University School of Medicine, and attending anesthesiologist, Sinai Hospital of Detroit

9:30 a.m. Applied Anesthesiology — "Anesthetic Considerations in Complications of Pregnancy" — Gertie F. Marx, MD, professor of anesthesiology, director of obstetric anesthesia, Albert Einstein College of Medicine, Bronx, NY

10:45 a.m. Permissible/Prohibitible Drugs — "Drugs and Smoking During Pregnancy" — Wendell W. Weber, MD, professor of pharmacology, University of Michigan Medical School, Ann Arbor

11:30 a.m. Teratology — "Rubella: Success with Problems" — John L. Sever, MD

Thursday Afternoon, March 6

1:30 p.m. Adolescent Pregnancy — "Decision Making by the Pregnant Adolescent" — Jack M. Stack, MD, president, Family Health Research Education and Service Institute, Alma — "Sociocultural Aspects of Adolescent Pregnancy" — Marilyn L. Poland, PhD, assistant professor, Department of Gynecology and Obstetrics, Wayne State University School of Medicine — "Michigan Improved Pregnancy Outcome (IPO) Program" — Darlene T. Hinkle, BSN, MS, administrator, Improved Pregnancy Outcome Program, Michigan Department of Public Health, Division of Maternal and Infant Health

Advance Registration

Please complete and mail to the Michigan Conference on Maternal and Perinatal Health, Box 950, East Lansing, MI 48823

Name _____

Please check one:

Address _____

Physician RN LPN Student Other

City _____ Zip _____

☐ ☐ ☐ ☐ ☐

Registration Fee:

Physician Nurse Other Student/House Officer

Please Check Wednesday Sessions

☐ \$15 ☐ \$8 ☐ \$8 ☐ No Charge

Thursday Sessions

☐ \$15 ☐ \$8 ☐ \$8 ☐ No Charge

Total

\$ _____ \$ _____ \$ _____ \$ (none) _____

Make checks payable to Michigan State Medical Society

MICHIGAN PHYSICIANS who are component and state society leaders should be making plans now to attend the 1980 AMA Leadership Conference. The four-day event is planned Feb. 21-24 at the downtown Marriott Hotel in Chicago. The fee is \$150. President Carter has been invited to discuss the administration's view of health care in the 80's for the Sunday wrap-up session.

MICHIGAN PHYSICIANS are alerted to the existence of a new organization designed to reach persons born of women who took the drug diethylstilbestrol during pregnancy. DES Information/Alert, a project of the Ingham County Women's Commission, is coordinating a statewide issue awareness campaign on DES exposure. DES was given to pregnant women from 1941 to 1971 and was thought to prevent miscarriage. It now is linked with medical problems in the offspring of women who took the drug. Serving on the new advisory board to the office are Arthur Kohrman, MD, associate dean of educational programs, MSU College of Human Medicine, and Eleanor Burden, MD, Lansing pathologist.

State's bed reduction plans being reworked, reviewed

Flint and Detroit-area bed reduction plans are back with their respective HSAs for reworking. The State-wide Health Coordinating Council Jan. 17 voted to return the two plans to the HSAs which formulated them. The Genesee-Lapeer-Shiawassee HSA is to provide more specifics on proposed hospital consolidations, while the Comprehensive Health Planning Council of Southeast Michigan is to work on six points which the CHPC-SEM already had identified as weaknesses. In addition, the CHPC-SEM is to work on further issues identified in public hearings. The CHPC has formed two committees to address the impact of the bed reductions on access to health care, on minorities, on emergency medical services, on unemployment/re-employment and on professional training. A key issue with the CHPC-SEM plan is the large responsibility for bed reductions carried by osteopathic training hospitals.

Senate now taking up BCBSM reform legislation

Hearings have begun in the Senate Commerce Committee on legislation (HB 4555) proposing reform of Blue Cross Blue Shield of Michigan and health care cost containment. Sen. Arthur Miller (D-Warren), committee chairman, announced general comments will be heard during three half-day hearings, then the bill will be reviewed section-by-section in a series of Tuesday afternoon hearings. Target for reporting the Senate version of the bill to the floor is late February, though few observers expect that timetable to hold. Major emphasis in the Senate probably will be placed on restructuring of the Blues' corporation, as opposed to the House's emphasis on cost containment.

Michigan State Medical Society
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East Lansing, Michigan 48823

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Editor: Judith Marr

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FEB 26 1980

Breaking News for Michigan Doctors

MEDIGRAM

CAPSULES

MSMS AND THE AMA Department of Negotiations are co-sponsoring a seminar entitled "Negotiation: A Leadership Skill," Feb. 16-17 at the Lansing Hilton Inn. The seminar is to improve physician's negotiation skills. These skills will benefit the medical community in both personal and professional transactions with hospital medical staff and administrators, health systems agencies, third party payors and medical societies. For further information, please contact William Madigan or Dennis Paradis at MSMS.

THE MSMS COUNCIL has instructed a subcommittee of the Steering Committee on Health Planning to develop an MSMS position paper on the bed reduction plans in Michigan. Members of this committee are: Kenneth J. Ray, MD, chairman; Billy Ben Baumann, MD; James D. Fryfogle, MD; Carl H. Gagliardi, MD; George H. Greidinger, MD; George A. Lightbourn, MD; Richard L. Rapport, MD; Charles L. Seifert, MD, and Robert J. Toteff, MD. This subcommittee will present a report to the MSMS Council on March 5.

Physicians who want to help develop this report to the Council may contact one of the committee members prior to Feb. 19, or may send their comments to Dennis Paradis, MSMS Physician/HSA Support Center, 120 W. Saginaw, E. Lansing, 48823.

Sports Medicine Conference registration form on page 3 inside

MSMS testifies on HB 4555

MSMS testified Feb. 5 that HB 4555, the bill to reform Blue Cross Blue Shield of Michigan, imposes the bureaucracy upon BCBSM. "Generally speaking," said Bruce Ambrose, manager, MSMS Department of Government Relations, "there is little if any evidence that the bureaucratic process is better than private initiative. Should events provide MSMS the opportunity to help further limit the encroachment of the bureaucracy upon the private sector, it will do what it can in that regard. MSMS is interested in lending its support to the ultimate purpose of the corporation, which is to assure Michigan citizens access to quality medical care."

Mr. Ambrose stated MSMS finds HB 4555 in need of improvement, and offered MSMS' suggestions for a better bill. The suggestions followed the guidelines approved by the MSMS Council Jan. 23 and reported in the Jan. 28 Medigram.

MSMS planners seek members' views

Do you have some well-formed opinions on future MSMS directions? If so, please express them to members of the MSMS Committee on Long-Range Planning. John R. Ylvisaker, MD, MSMS president-elect, chairs the committee. Members are Susan E. Adelman, MD; Daniel R. Barr, MD; Harold I. Blumenstein, MD; Donald K. Crandall, MD; Larry W. Fitzsimmons, MD; Robert H. Hamburg, MD; William R. Harlan, MD; Richard C. Hausler, MD; Kenneth E. Pitts, MD, and Natalia M. Tanner, MD.

The new Task Force on MSMS Structure will work to assure that the MSMS organization fits the goals defined by the Long-Range Planning Committee. Donald N. Sweeny, Jr., MD, Detroit, heads the task force.

COPIES OF THE PATIENT FOLDER, "To Your Good Health" are still available from MSMS. This excellent folder explains in layman's terms health care costs and offers basic health tips. More than 20,000 copies of this folder have been distributed. To order, please send your name and address and check for quantity desired (\$4 per hundred folders) to MSMS, Box 950, E. Lansing, 48823, attention Mert Scholten.

DON'T MISS YOUR OPPORTUNITY to register for the 1980 Michigan Conference on Maternal and Perinatal Health! The official registration form for the March 5-6 event at the Hyatt Regency Dearborn appears on page 10 of the January Michigan Medicine and inside the Jan. 28 Medigram newsletter. When you make your hotel reservations, be sure to mention you are attending the conference, to obtain special room rates.

THE MSMS BUREAU OF ECONOMICS is reorganizing and expanding. Its new physician advisory committee is to maintain a broad philosophical view of the entire health care delivery and financing structure. Jay Harness, MD, Detroit, heads the advisory committee, which also will help MSMS develop specific policies and methods of serving MSMS members as health care delivery changes.

THE THREE MSMS REPRESENTATIVES to the Statewide House Officers Training System (SHOTS) will serve another year, as MSMS Council Chairman Louis R. Zako, MD, has reappointed them. They are Harold E. Crow, MD, Lansing; Murray N. Deighton, MD, and Henry W. Maicki, MD, both of Southfield.

Professional Standards Review Council awaits approval to hear reviews appeal

The new Michigan Statewide Professional Standards Review Council is awaiting federal approval to begin hearing appeals of local PSRO decisions. The Michigan council expects word soon from the Chicago regional office of the new Department of Health and Human Resources (formerly HEW). Typical of the appeals it will handle are those made by providers or recipients when a patient's stay in a hospital has been denied by the local PSRO, the hospital costs involved exceed \$100 and one or both parties is not satisfied by any earlier avenues of redress. The Statewide Council has just established its permanent offices in the Stockwell Building near MSMS headquarters. Executive Director is Nancy Greenawalt, formerly staff on PSRO matters to the Michigan Medicaid program. The Statewide PSR Council serves as a professional association to assist PSROs in achieving a coordinated approach to PSRO legislative objectives.

The Michigan PSR Council is one of approximately 15 which eventually will be in operation around the country. States must have at least three conditional PSROs to qualify to form a state council. Physicians on the 18-member board of the Michigan Council are Mary O. Anderson, MD, Leonidas; Stanley M. Beck, MD, Gaylord; John B. Bryan, MD, Royal Oak; Arthur P. Bumstead, DO, Saginaw; Ralph R. Cooper, MD, Detroit; Frederick W. Van Duyne, MD, Flint; Daniel J. Fall, MD, Ann Arbor; Raymond Gadowski, DO, Detroit; Perry W. Greene, Jr., MD, Grand Rapids; Rhoda Powsner, MD, Ann Arbor; Daher B. Rahi, DO, St. Clair Shores; Jack Ryan, MD, Detroit; Douglas D. Sherk, MD, Marquette, and Bernard H. Smookler, MD, Lansing.

Board offers special license to Lafayette Clinic nominee

Samuel Gershon, MD, Australian psychopharmacologist nominated by the Department of Mental Health to be director of Lafayette Clinic has been offered a clinical academic license by the Board of Medicine. The limited license, based upon Doctor Gershon's outstanding credentials and achievements, was voted by the board following legislative action to bring Doctor Gershon to Michigan without examination. It was not known whether Doctor Gershon would accept the clinical academic license.

1980 Conference on Sports Medicine

**Thursday, April 10, 1980
Long's Convention Center
Lansing**

Sponsored by Michigan State Medical Society

The Michigan State Medical Society will grant 6 hours of Category I continuing medical education credit toward the state requirements. AAFP prescribed credits for family physicians also will be awarded.



- 8 a.m. Registration and coffee
- 9 a.m. Welcome: Edwin R. Guise, MD, conference chairman
- 9:05 a.m. "Women in Athletics"
Rose Snyder, ATC, Athletic Medicine Institute, Henry Ford Hospital
- 9:45 a.m. "Swimmer's Shoulder"
Jerome Ciullo, MD, Dept. of Orthopedic Surgery, Henry Ford Hospital
- 10:25 a.m. Coffee Break
- 10:40 a.m. "Tennis — The Fun; The Problems"
Neal Marcus, MD, Dept. of Orthopedic Surgery, Henry Ford Hospital
- 11:15 a.m. "Medical Problems of Competitive Runners and Garden Variety Joggers"
Robert Teitge, MD, Stanford University Sports Medicine Clinic, Palo Alto, CA
- 12:15 p.m. Luncheon
Charles Zimont, MD, chairman, MSMS Sports Medicine Committee, Presiding
- 1:30 p.m. "Prevention, Protection and Recognition of Head and Neck Injuries"
Joseph Godfrey, MD, Orthopedic Surgeon, Buffalo, NY (former team physician for Buffalo Bills)
- 2:10 p.m. "Rehabilitation in High School Athletics"
Lou Meeks, MD, Orthopedic Surgeon, Ypsilanti
- 2:50 p.m. Coffee Break
- 3:05 p.m. "Current Trends in Weight Training"
Mike Kittleson, Weight Training Coach, University of Michigan, Ann Arbor
- 3:45 p.m. "The Recognition and Diagnosis of Knee Joint Difficulties"
Joseph Godfrey, MD, Buffalo, NY
- 4:25 p.m. Summary and Closing Comments
Doctor Guise

REGISTRATION FORM

Please return to: MSMS Sports Medicine Conference

PO Box 950, East Lansing, MI 48823 Phone: 517/337-1351

Name _____

Address _____

City _____ State _____ Zip _____

Check one: (Registration fee includes lunch)

☐ Physician (\$20) ☐ Trainer (\$15) ☐ Coach (\$15) ☐ Other (\$15)

Please make checks payable to Michigan State Medical Society

IT'S JUST SIX WEEKS to the deadline for resolutions to be considered at the 1980 MSMS House of Delegates meeting. The annual meeting is scheduled April 25-27 at the Michigan Inn, Southfield. House of Delegates procedure requires resolutions to be submitted 30 days prior to the meeting. A mailing will go soon to all delegates and alternates named by the component and specialty societies. Further information is available from Richard Campau at MSMS headquarters.

HERBERT MEHLER, long-time MSMS employee, retired Jan. 31. Mr. Mehler served in several MSMS positions, most recently as project coordinator for the AMA-funded efforts to improve health care delivery in Michigan jails. Before that, he was director of the Michigan PSRO Support Center. David M. Schut, December 1979 University of Michigan graduate, is new assistant coordinator for the jails project, succeeding Mr. Mehler. He is working under the direction of Richard Campau. Mr. Schut has a degree in health science communications and is the son of Almon Schut, MD, Kalamazoo ophthalmologist.

MSMS questions FTC

MSMS legal counsel filed extensive interrogatories (written questions) in mid January which require the Federal Trade Commission to give all the factual details supporting the allegations in its complaint filed against MSMS. Legal counsel expects answers or objections in mid February. MSMS legal counsel has not completed its search of thousands of FTC documents, an earlier phase of the pre-trial discovery process. The trial is set for June 2, probably in Washington.

OCMS regrouping for HMO

Oakland County Medical Society members expect to return to their HSA Feb. 26 to discuss a certificate of need for their proposed IPA-type HMO. Several consumer members of the Project Review Committee of the Comprehensive Health Planning Council of Southeast Michigan (CHPC-SEM) were concerned about physician sponsorship and physician board membership in the 350 physicians' initial request for licensure. "Each of their concerns has been effectively refuted, and initial documentation will be made to committee members," states Billy Ben Baumann, MD, OCMS president. The CHPC-SEM only can review and comment on the HMO proposal. The Michigan Department of Public Health and Michigan Insurance Bureau make the final decision on the HMO's existence.

Sports Medicine Conference registration form on page 3

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Editor: Judith Marr

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MICHIGAN MEDICINE

February 1980

JOURNAL OF THE MICHIGAN STATE MEDICAL SOCIETY

Vol. 79, No. 5



Who to call at MSMS headquarters

Advertising (in <i>Michigan Medicine</i>)	Bonnie Groff
AMA Delegation	Bruce Ambrose, Wayne Burmeister
Annual Scientific Meeting	
Program	Sherry Fent
Meeting Arrangements	Marce Ireland
Arbitration	Bill Madigan
Auto Lease Plan	Wayne Burmeister
Blue Cross Blue Shield	John Richards
Board of Medicine	Gary Anderson
Continuing Medical Education	
Accreditation	Marce Ireland
Category I Calendar (for <i>Michigan Medicine</i>)	Bonnie Groff
MSMS-Sponsored Conferences	Sherry Fent
Dues Payments	M. C. Lee
Financial Operations	Dick Campau
Foreign Medical Graduates	Mert Scholten
Governmental Agencies Liaison	Sherry Wellman
Health Career Information	Mert Scholten
HMOs (Health Maintenance Organizations)	Dick Campau
HSA Support Center	Dennis Paradis
Impaired Physicians	Mert Scholten
Jail Health Project	David Schut
Judicial Commission	Vada Davis
Legislation	Bruce Ambrose
Maternal Health Committee and Conference	Katie Brewbaker
Medicaid	Sherry Wellman
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Medical Care Costs	Dick Campau
Medical Ethics	Vada Davis
Medigram	Judy Marr
Meeting Information (National, State)	Bonnie Groff
Member Services	Wayne Burmeister
Membership Records	Peg Berry
Michigan Association for Medical Education	Tanya Miller
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Michigan Society of Anesthesiologists	Tanya Miller
Michigan Society of General Surgeons	Caroline Rich
Michigan Society of Respiratory Therapists	Caroline Rich
MSMS Committee Meeting Schedule	Katie Brewbaker
MSMS House of Delegates	
Agenda and Schedule	Dick Campau
Meeting Arrangements	Marce Ireland
MSMS-Sponsored Insurance Programs (Life, Health, etc.)	Wayne Burmeister
MSMS Travel Programs	Marce Ireland
MSMS News Relations	Mert Scholten
Physicians' Assistants	
Certification	Sherry Wellman
Programs	Mert Scholten
Physician Hospital Relations	Dick Campau
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Practice Management Seminars	John Anthony
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PSRO/Peer Review	Dick Campau
Socio-Economic Surveys	John Richards
Specialty Societies	
Information	Katie Brewbaker
Council of Specialty Societies	Bill Madigan
Third Party Payors	John Richards

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MICHIGAN MEDICINE

Campaign buttons, and a few from MDPAC and AMPAC draw our attention to the strong political currents of this year. For the full story, please see our special report beginning on page 51. (Cover photo by Mert Scholten)

MICHIGAN MEDICINE

February 1980, Volume 79, Number 5

Special report

- 51** 1980 is a crucial political year, and MDPAC and AMPAC are working hard to assure organized medicine's views are effectively represented. For why it's crucial, and what they're doing about it, see this special report by Thomas C. Payne, MD; Willah Weddon and Thomas R. Berglund, MD.

Features

- 58** How the Romans cared for their ill and injured along Hadrian's Wall; Orville Oughtred, MD
- 65** Ophthalmology fights encroachments of skilled technicians in Michigan; Philip C. Hessburg, MD, and Justin L. Moran
- 68** Here's what's happened to Michigan physicians' suggestions for medical benefits in UAW/auto contacts; B. J. Iserman, DBA
- 70** Michigan physicians, scientists begin to deal with public concern over nuclear medicine waste; Charles Downs
- 72** The Michigan Department of Social Services: Part three of a series; Sherry Nolte Wellman
- 77** What medical education is doing to provide physicians for Michigan; Robert K. Richards, PhD, and Ann Maxwell Eward
- 84** The MSMS Department of Operations and Member Services
- 89** Photo highlights of the 1979 MSMS Annual Scientific Meeting

Departments

- 46** Editorial; Busharat Ahmad, MD
- 47** Letters
- 56** Health planning update
- 80** Ad index
- 82** MSMS/A
- 92** News
- 94** Meetings
- 96** Category I courses
- 99** Deaths
- 100** New members
- 101** Classified advertising
- 102** President's page

Let us join ophthalmology in its fight for survival

By Busharat Ahmad, MD, Marquette



P rivate practice of medicine is under attack not only by the politicians and so-called "consumer advocates," but also by organized labor and by profit-motivated commercial corporations.

This is becoming very apparent in our state with regard to ophthalmology. It behooves us to watch and help this specialty in its fight to survive because the rest of us may be facing this same fate very soon. (Please see page 65)

Ophthalmology's fight at this time is primarily against optometry, which wants to be the "primary care provider" and is using mass media advertising and aggressive legislative efforts to attain this goal. Recent entry in this area is the large corporation whose aim is to profit through its commercial outlets using advertising media and optometric services.

Michigan Ophthalmologic Society is doing a good job in fighting these encroachments on the private practice of medicine. But MOS needs help from all of us non-ophthalmologists, as it is fighting its battle for all of us.

We can help the ophthalmologist by making sure that when patients are referred for eye care, they are sent to an ophthalmologist and not an optometrist. An ophthalmologist is an MD trained in the care of disease and surgery of the eye, which includes the prescription of glasses and contact lenses. An optometrist is a non-physician and has no training to diagnose or treat diseases of the eye.

We should also help ophthalmology in its fight to stop optometry from obtaining rights to use diagnostic pharmaceutical drugs through legislative efforts. Optometrists have not attended medical school and have no medical background, and should not be allowed to use eye drops.

Entry into the field of ophthalmology by major corporations through vision care programs and retail outlets is foreboding for all of medicine. We all should help in education of our colleagues and consumers in keeping the practice of medicine free of these encroachments. Michigan ophthalmologists' concern also is reflected by their national organization which has picked up this gauntlet of intrusion by paramedical personnel into the private practice of ophthalmology. During the last annual meeting of the American Academy of Ophthalmology in San Francisco in November, 1979, a secretary for governmental relations was appointed, who will help to coordinate its socio-economic affairs. This action was heightened by recent developments in Michigan and other states.

As Frederick Blodi, MD, of the American Academy of Ophthalmology said, "Never before has American ophthalmology been so united and determined to combat invasions into the medical practice by paramedical personnel and to repulse unwarranted interference by governmental agencies into the activities of a learned profession."

Let us all join ophthalmology in its fight for survival. They need us at this time. We might be the next target of these paramedical organizations and governmental agencies for control of medicine. Maybe we are all on this battlefield already.

Michigan State Medical Society
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Judith Marr

Michigan Medicine, the official journal of the Michigan State Society, is dedicated to provide useful information for Michigan physicians about actions of the Michigan State Medical Society and contemporary issues, with special emphasis on socio-economics, legislation and news about medicine in Michigan. Major medical developments will be reported and interpreted as has been the custom.

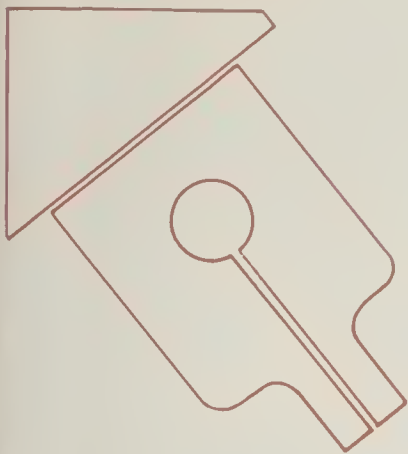
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LETTERS



Physicians may call USP toll-free number to report drug problems

Health care professionals now can dial a toll-free telephone number to report problems they've experienced with drugs, medical devices and in vitro diagnostic products. The number is 800-638-6725 (in Maryland, call collect (301) 881-0256).

The Food and Drug Administration encourages health professionals to report:

- Hazardous or potentially hazardous products;
- Product mislabeling or improper labeling;
- Incomplete or confusing instructions;
- Erroneous information;
- Designs that encourage human error;
- Performance failures;
- Non-sterile products;
- Packaging errors;
- Defective components;
- Quality control problems; and
- Any other situation that could affect the safety and efficacy of a product.

These problem reports help FDA determine when a product poses a significant potential hazard to health, sometimes necessitating a recall. The information also is used to detect recurring or widespread problems and to search out deficiencies useful in developing profiles and trends of manufacturer and/or product problems that might suggest needed amendment of performance or good manufacturing standards.

Joseph G. Valentino
Executive Associate
U.S. Pharmacopeia
Rockville, MD

Indochinese refugees in Michigan bring along several health problems

The number of Indochinese refugees arriving in Michigan is increasing monthly. This population brings with it several health problems we all should be aware of. Although initial screening usually will be carried out by county health authorities, referrals for individual problems and follow-up care frequently will be made to private practitioners.

I would like to take this opportunity to briefly outline some of the more important points regarding these refugees.

1. **Tuberculosis:** This is the most serious potential public health problem posed by the incoming refugees. It is estimated that as many as 2 percent may have "active" tuberculosis. It is recommended that treatment of those cases with positive sputum culture and/or cavitory lesions consist of INH, rifampin, and ethambutol, since up to 10 percent of the organisms may be INH-resistant. Prophylactic therapy for contacts should be, as usual, with INH. Skin test results should be interpreted as usual, and the possibility of prior BCG vaccination should be ignored.

2. **Malaria:** Thick blood films of all refugees who report fever should be prepared and examined for malarial parasites. Other symptoms include anemia, splenomegaly, chills, headache, backache, and malaise. *Plasmodium falciparum* malaria, resistant to chloroquin, is endemic in southeast Asia, and, when treating presumptively, this should be borne in mind.

3. **Other parasitic infections:** Enteric parasites are common in this population, but, because of sewage disposal systems in this country, they do not represent a public health problem. It is recommended that screening for intestinal parasites not be performed on asymptomatic patients, but that this possibility be evaluated in those persons presenting with gastro-intestinal symptoms.

4. **Hepatitis B:** 10-15% of incoming refugees may be asymptomatic carriers of hepatitis B surface anti-

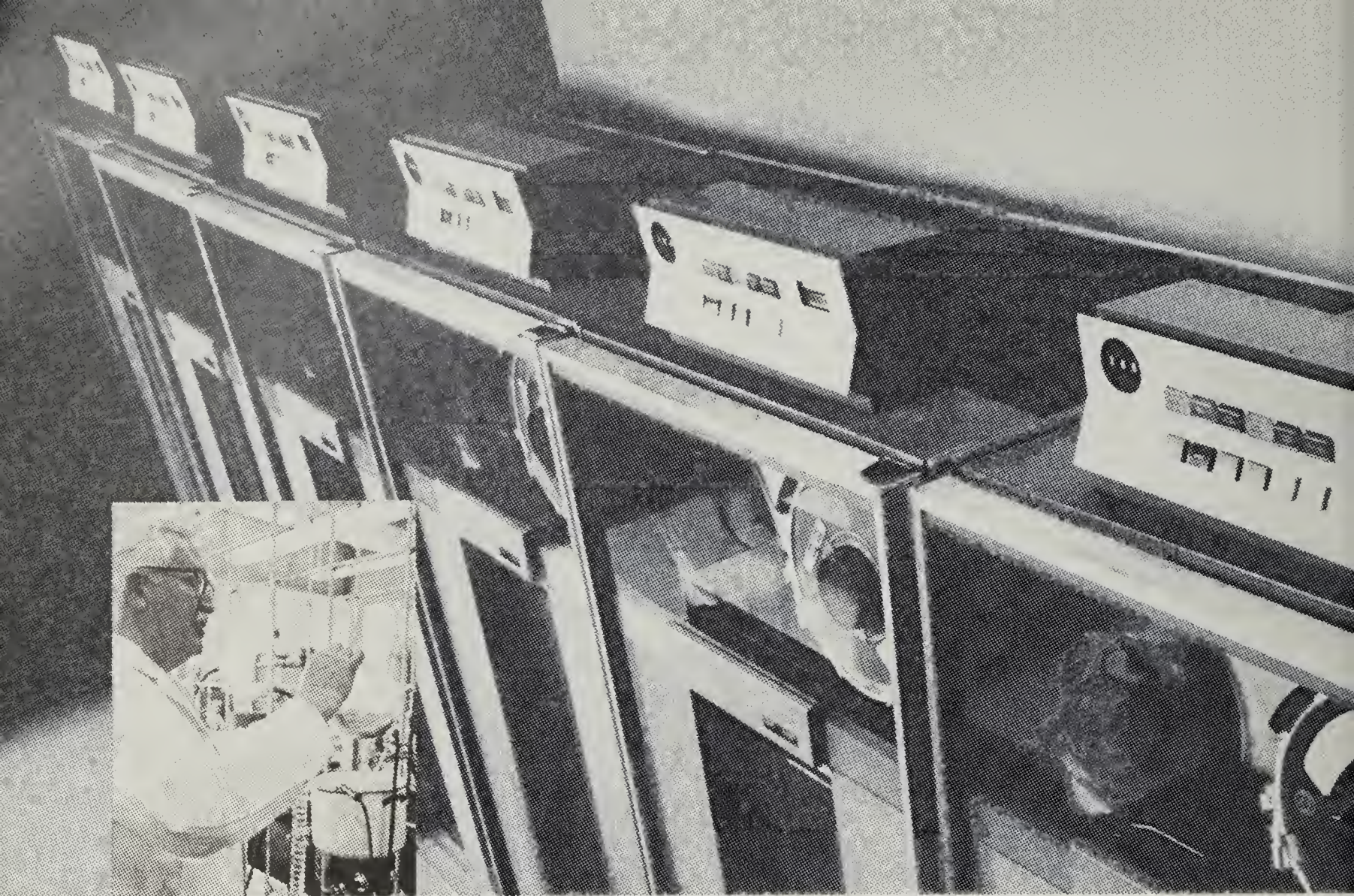
gen. This would increase the pool of carriers in this country by 4%. Although increased risk to the general population is probably negligible, certain sub-groups (neonates, health personnel, and host families) may be at increased risk. Accordingly, testing for HBsAg should be routine for all incoming refugees, especially women of child-bearing age. Dental personnel should seriously consider taking special precautions when dealing with known carriers. Furthermore, it is recommended that children born to carrier mothers receive immune serum globulin (ISG) no later than 48 hours after birth.

5. It is of utmost importance that proper attention be paid to making sure that immunization records are complete.

This letter is brief and is intended only to promote an increased level of awareness. It is strongly suggested that any practitioner dealing with recently-arrived refugees refer to the August 24th, and October 5th issues of the Morbidity and Mortality weekly report published by the Center for Disease Control, Michigan Department of Public Health, for a more complete discussion of these questions. In addition, I would be happy to discuss any individual cases by telephone at any time.

Sincerely,

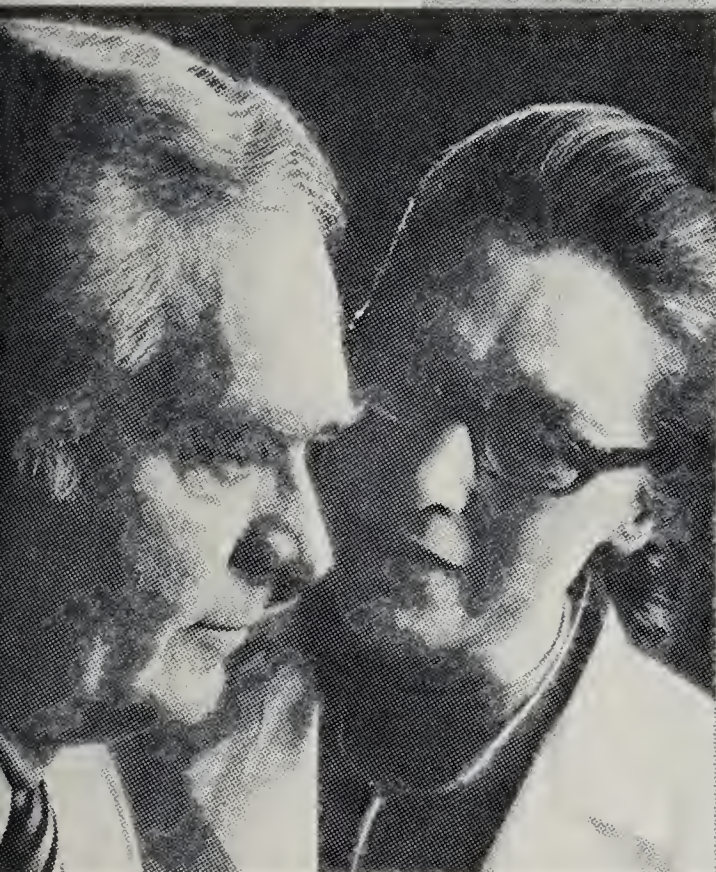
Ronald J. Waldman, MD, MPH
EIS Officer — Michigan
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Before prescribing, please consult complete product information, a summary of which follows:

Indications: Relief of anxiety and tension occurring alone or accompanying various disease states. Efficacy beyond four months not established by systematic clinical studies. Periodic reassessment of therapy recommended.

Contraindications: Patients with known hypersensitivity to the drug

Warnings: Warn patients that mental and/or physical abilities required for tasks such as driving or operating machinery may be impaired, as may be mental alertness in children, and that concomitant use with alcohol or CNS depressants may have an additive effect. Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage, withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported.

Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression, suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction, changes in EEG patterns (low-voltage fast activity) may appear during and after treatment, blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

Usual Daily Dosage: Individualize for maximum beneficial effects. *Oral—Adults:* Mild and moderate anxiety and tension, 5 or 10 mg *t.i.d.* or *q.i.d.*, severe states, 20 or 25 mg *t.i.d.* or *q.i.d.*. *Geriatric patients:* 5 mg *b.i.d.* to *q.i.d.* (See Precautions.)

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Artwork courtesy the American Society of Internal Medicine

How to kill an association

Don't participate beyond paying your dues — let "them" handle things.

Then complain that members have no voice in management.

Decline all offices and committee appointments — you're too busy.

Then offer vociferous advice on how they should do things.

If appointed to a committee, don't work — it's a courtesy appointment.

Then complain because the organization has stagnated.

If you do attend management meetings, don't initiate new ideas.

Then you can play "devil's advocate" to those ideas submitted by others.

Don't rush to pay your dues — they're too high anyway.

Then complain about poor financial management.

Don't encourage others to become members — that's selling.

Then complain that membership is not growing.

Don't read the mail from headquarters — it's not important.

Then complain that you're not kept informed.

Don't volunteer your talents — that's ego fulfillment.

Then complain that you're never asked; never appreciated.

And, if by chance, the organization grows in spite of your contributions

Grasp every opportunity to tell the youngsters how tough it was; how hard you worked in the old days to bring the organization to its present level of success.

(Reprinted from the Journal of The Virginia Academy of Family Practice)

MDPAC recharging to meet 80's challenges

By Thomas C. Payne, MD, chairman
Michigan Doctors Political Action Committee



The Board of Directors of the Michigan Doctors Political Action Committee is putting forth a major effort this year to develop physician participation in political action. This effort is based on the board's desire to build a sizeable campaign fund and its recognition that the 1980 elections will have a significant impact on the legislative initiatives of the next decade.

The MDPAC Board recognizes the importance of having sufficient funds available to have an impact on the political races. For this reason, the Board unanimously raised the requested contribution level from \$25 to \$50 for regular membership and \$150 for sustaining membership as part of the joint MDPAC/AMPAC fund raising effort.

In addition, the MDPAC Board is closely watching the 1980 population census, which will become the basis of reapportionment plans for redistricting of legislative seats for the next 10 years. The manner in which the lines are drawn will have a significant impact on which political party and philosophy will control both federal and state government.

More legislation

Simultaneously the MDPAC Board is monitoring legislative rumblings which may drastically affect the future operation of all political action committees. Federal legislation already has passed the U.S. House of Representatives limiting the monetary contributions PACs can make to congressional candidates. This amounts to an incumbency guarantee, making it difficult for challengers to amass the necessary financial support to unseat an incumbent. For MDPAC and other PACs to survive such legislative challenges to their activities, they must become sophisticated in their efforts to help candidates.

This recent proposed legislation to restrict PAC contributions is the latest evidence of a trend established in the aftermath of Watergate. There followed a deluge of political reform through federal and state legislation and regulation. In 1976, funding of political campaigns and a demand for public scrutiny of politicians' resources resulted in comprehensive and complex reporting requirements for both the recipient and donors of

political contributions in Michigan. At the same time, as more and more groups and their constituents recognized the importance of becoming involved in political action, proliferation of PACs was unprecedented.

In 1976, when Michigan enacted its campaign reform legislation requiring PACs to report, there were only 30 business and professional groups which had organized PACs. Michigan Doctors Political Action Committee was one of them. Collectively, these separate groups raised only \$180,000 for the purpose of political campaigns. In less than two years, prior to the 1978 election, 143 Michigan business and professional groups had organized political action committees amassing a staggering figure of \$2,100,000 for the 1978 elections.

This growth has not gone unnoticed. It is not unreasonable to assume that new amendments and modifications to the Campaign Finance Act will be coming. These changes will further challenge the ability of business and professional groups to support candidates sympathetic to their concerns and philosophies in the legislative arena. More restrictions will demand that political action committees become more sophisticated in their operation, offering support to candidates in the form of in-kind contributions and independent expenditures.

New dimension

The nature and success of political action committees will no longer rest solely on their ability to raise

money. A new dimension will be added — the ability of the PAC to mobilize its members to support the candidates of their choice, an invaluable commodity in any campaign.

The advantage any constituent association has through its political action committee is the ability it possesses to gather political and statistical information relative to candidates' chances of winning, months before an election. The PAC uses this information, relates it to the candidate's philosophical positions and coordinates the financial and human resources necessary to affect an election.

The Michigan Doctors Political Action Committee is in the process of making changes which its board feels are necessary to meet the legislative challenges which loom on the horizon. The Michigan Doctors Political Action Committee has become an integral part of organized medicine's legislative activities.

MDPAC offers the physicians of Michigan an organization capable of collectively supporting candidates who understand the imperatives of quality health care and who represent the basic social principles and philosophies by which the majority of physicians function.

Physician support of MDPAC helps assure the survival of the medical profession as it has existed and the philosophy by which it has operated. The efforts of MDPAC in the legislative process make sure its concerns and objectives are expressed on the floor of the Congress and the State Legislature.

1980 presidential election, national census to have profound effects for medicine

By Willah Weddon, Special to Michigan Medicine



"I think the 1980's are going to be a fight for survival on the part of physician-providers as we see their role today," Mel Larsen, chairman of Michigan's Republican Central Committee, says candidly.

"1980 will be critical from a professional point. We're still dealing with national health programs which could have a tremendous impact on the country."

Non-involvement out

"The day of non-participation on the part of professional organizations in the election process has passed," he continued.

"With the amount of regulation and taxation on individual as well as professional lives, it mandates deep involvement in the election process as well as the legislative process. You cannot be effective in influencing public policy if you do not get involved in elections."

Olivia Maynard, chairperson of the Michigan Democratic Party, looks to 1980 with the hope that more physicians will become involved in politics.

"The thing that motivated many physicians when they decided to enter medicine was a concern for people and a desire to help them," she says. "Politics is all about caring for people . . . political involvement is putting that concern into action."

"The more caring, concerned people, including physicians, who get involved, the better will be our response to the many problems and issues awaiting the state's and this nation's attention."

Governor William G. Milliken looks ahead to the 1980's with a great sense of challenge and anticipation. "I think the 1980's are going to be good years for the people of Michigan and for the country," he says. "I think our system of government over all these some 200 years has shown it

is a system that can endure, can become strong and is responsive."

The most immediate concern may be tied to the State's budget.

No money

"There is little money in the State this year," Bruce Ambrose, MSMS Manager of Government Relations, succinctly describes the financial situation.

This, he points out, will affect all public health programs such as Medicaid, implementation of the new Public Health Code and funds for medical education.

From the long-range point of view, however, reapportionment based on the 1980 census may create the greatest change. Larsen, who has also served in the state legislature, sees it as a major issue, although redistricting won't go into effect until 1982.

"When you look at the total vote for the House and Senate in Michigan during the last election, Republican candidates took about 46 percent. But they reflect only about 30 percent of the actual members seated," he points out.

"So a great deal of effort will have to go into developing a reapportionment plan the State Supreme Court will accept."

This gets to the politics of the Court. Chief Justice Mary S. Coleman and Justice Charles L. Levin will be up for re-election in 1980.

Both political parties will be concentrating on the court election in 1980. Justice Coleman was nominated by the Republicans and Justice Levin ran as an independent, eight years ago. The court will be working on apportionment plans after the census report is made available, as mandated by law, in April 1981.

socializing anything, and pointed out during a visit to Michigan, "There are 164 different agencies regulating hospitals. The paper work connected with them adds \$35 per patient to the hospital cost."

John Anderson, Republican Congressman from Illinois, represents the liberal wing of the GOP among presidential hopefuls. He has a strong following among members of the medical community in his home state. Between these two extremes, other GOP presidential candidates may emerge stronger in months ahead.

Although a President's power to influence Congress has dwindled, appointments have a direct bearing on the medical profession. Selection of the Secretary of the pending Department of Health and Human Resources is a case in point.

Congress is expected to act on a new graduate medical education bill this year, which may control the number of physicians in various specialties according to projected needs in 1990. Also, the Drug Enforcement Act (DEA) faces rewriting with emphasis on curbing drugs that reach the general public through illicit prescriptions.

If the House-passed provision to decrease the amount of funds which can be contributed to a Congressional candidate by political action committees is approved by the Senate, it could have tremendous impact. All

435 Congressmen are up for re-election in 1980, including Michigan's 13 Democrats and 6 Republicans. Incumbents would benefit.

Michigan problems

The year ahead holds similar problems for Michigan. Legislation to affect campaign funding, to alter the hospital bed reduction program, to reform Blue Cross and Blue Shield of Michigan and many others all will be affected in 1980 by the fact that the Michigan House of Representatives will be re-elected next November.

There is strong sentiment in both chambers to support legislation to restrict campaign funding by political action committees. This is viewed by others as an attempt to retain incumbents and to extend public funding of House and Senate races. In reference to this, Governor Milliken takes a "very cautious approach," saying "I'd like to know, first of all, how well we are doing with the system we currently have which calls for public funding of gubernatorial races."

Medically related legislation covers a wide range from legislator's personal interests to approval of plans virtually mandated by the federal government. Blue Cross Blue Shield of Michigan may face new regulations if reform legislation is enacted as expected.

Looking at 1980 from the perspective of physicians, Larsen points to the fact that government is still dealing with cost-containment, pumping more money into Medicaid and Medicare and placing more responsibility on physicians.

"I think elected officials only want to deliver on 80 percent of what they've promised to the people and they want the other 20 percent or more to be provided by the providers," he says. "Unless there is a change in public policy, this percentage will grow."

Presidential politics

Much of the political focus in 1980 will be on the presidential election.

Presidential candidate Ted Kennedy's emphasis in the national health insurance field forces President Jimmy Carter to move in a similar direction, despite his concern as to whether or not the country can afford it.

U.S. Congressman Henry A. Waxman (D-California), has urged physicians to be knowledgeable about the Kennedy-Waxman bill "because it is different than any proposed before" in the field of national health insurance. In an address to the AMA National Conference on State Legislation in Phoenix, Jan. 3-6, Waxman predicted there would be no action taken this year on NHI although Congress will debate Louisiana Democratic Senator Russell B. Long's catastrophic illness insurance bill and Carter's bill may be debated.

In the Republican camp, front-runner Ronald Reagan has a conservative background. He is opposed to

The tax implications of MDPAC/AMPAC contributions

A limited federal income tax credit is available for physicians' MDPAC/AMPAC contributions, according to MSMS legal counsel, while a limited deduction is allowed on state income tax reporting forms.

The federal credit may be taken on either Form 1040 or Form 1040A, says attorney John Shoemaker of Kerr, Russell and Weber of Detroit.

The credit is equal to 50 percent of total contributions subject to a yearly maximum of \$50 (\$100 for taxpayers filing joint returns). Corporations, estates and trusts cannot claim this credit.

To qualify for the credit, the contribution must be made to

(1) A candidate for federal, state or local elective office in a primary, general or special election;

(2) An organization or committee organized exclusively to support one or more candidates for federal, state or local elective offices, or

(3) A national, state or local committee of a national political party.

Physicians' contributions fit the second category, Mr. Shoemaker points out.

On their state income tax returns individuals (but not corporations) may deduct their contributions from federal adjusted gross income up to \$50 per year (up to \$100 in the case of a joint return).

AMPAC spends physicians' dollars wisely

By Thomas R. Berglund, MD, Portage, AMPAC Board



“Without the help of the medical community in my district, I would not have been elected to Congress.”

This is an actual quote from Congressman George O'Brien (R-17) of Illinois regarding his narrow election victory in 1974 and his victories since that time.

It is also the best thing that can be said about medical political activity by a candidate. It is AMPAC's hope to have victorious candidates throughout the United States saying the same thing.

Since AMPAC was formed in 1961, its purpose has been two-fold: to educate physicians in sophisticated political activity and to help the physician spend his political dollar wisely.

AMPAC is the second oldest national political action committee, second only to the AFL-CIO's COPE. This is because in the early 60's physicians saw the need for concerted political action. Most state medical political action committees, which jointly raise funds with AMPAC, also were formed in the early 60's.

Contributions to AMPAC are voluntary and are specified for political action at the state and/or federal level. AMPAC solicits contributions only for US Senate and US House races.

How AMPAC spends

AMPAC spends its money wisely where it will do the most good. It

avoids supporting sure winners and sure losers.

AMPAC, for the most part, also supports candidates that are supported by the local medical community.

AMPAC is a bipartisan political action committee and as such supports candidates of both major parties. In addition, AMPAC supports the congressional, senatorial and national committees of both major parties. The leaders of both major parties, in return, support the concept of medical political action.

AMPAC uses other criteria, in addition to local medical community support, to evaluate whether or not funds should be contributed to a candidate.

If the candidate is an incumbent, he has a better chance of winning due to the benefits of holding the office. Incumbency is the best insurance in winning an election.

AMPAC supports candidates in the following order: friendly incumbents who are in trouble; friendly candidates in an open race; and, friendly challengers to unfriendly incumbents. Also, if a candidate won his last election by less than 55% of the vote in a two-man race, that candidate is considered vulnerable to defeat and special attention is paid to such statistically marginal races.

When AMPAC makes candidate support decisions, it does not use commitment to health legislation as a criteria. Neither does it use party label or evaluation of a candidate's voting record.

AMPAC encourages individual physicians to use the same kind of objective political criteria in evaluating their local campaigns. And, while medical and health issues are important to physicians, AMPAC encourages the medical community to base its support on the candidate's stance on many issues, as well as his or her suitability for the local congressional district.

AMPAC's track record

Contributions to AMPAC are on an annual basis. Political activity is year round and the term "election year" means merely that the election is held in that year.

1979 was AMPAC's most active "off year" for election activity. In getting ready for 1980, AMPAC already has supported 162 congressional candidates for the 1980 elections. AMPAC contributed to 148 US House candidates and 14 US Senate candidates in 1979.

During 1977 and 1978, AMPAC supported 415 candidates for the 1978 elections. Of this number, 367 candidates were running for the US House and 48 were running for the US Senate. 74.7% of the candidates AMPAC supported in 1978 elections were successful.

For the first time, AMPAC made independent expenditures on behalf of candidates. AMPAC supported 16 House candidates and one Senate candidate through one-page ads in national magazines. In addition, AMPAC supported 10 candidates by supplying county committees of the candidates' parties with campaign buttons for distribution before the election.

This was AMPAC's first venture in this kind of expenditure, and it moved cautiously. Some political experts feel that independent expenditures, that is those expenditures made on behalf of a candidate but without his knowledge and consultation, may be the wave of the future for political action committees and other groups who support federal candidates.

The years ahead

Looking ahead to 1980 and beyond, AMPAC will continue to encourage physicians and their spouses to serve as delegates and alternate

continued on page 56

DESCRIPTION: Methyltestosterone is 17 β -Hydroxy-17-Methylandrosta-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunuchism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-puberal cryptorchidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric,

avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE**

REACTIONS: Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. **In the male:** Eunuchoidism and eunuchism, 10 to 40 mg. Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg. Postpuberal cryptorchism, 30 mg. **REFERENCE:** R. B. Greenblatt, M.D.; R. Witherington, M.D.; I. B. Sipahoglu, M.D.: Hormones for Improved Sexuality in the Male and the Female Climacteric. *Drug Therapy*, Sept. 1976. **SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only.

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HEALTH PLANNING UPDATE

**By Dennis Paradis, Director
MSMS Physician/HSA Support Center**

Report to the Specialty Societies

In October, 1979 a letter was sent to 40 Michigan specialty societies asking if they would comment on the coming State Health Plan (SHP). Fourteen specialty societies responded that they would review the SHP and send comments for presentation to the Statewide Health Coordinating Council. Four societies did, in fact, send comments.

The State Health Plan is the guiding policy document for health care in Michigan. The development of the plan is an excellent area for specialty societies to have an impact with their unique philosophy and expertise in health care. However, the short time frame which is allotted for public comments requires that specialty societies have a health planning mechanism in place and policy statements already developed on relevant issues. If any specialty society wishes to discuss the development of a health planning committee, it may contact the MSMS Physician/HSA Support Center.

CAT Scanner inventors get Nobel Prize

The CAT Scanner has been regarded by health planners as an expensive piece of machinery and a prime target of cost-cutting. But recently, the scientists who developed the CAT received the Nobel Prize for physiology and medicine. The Nobel citation reads: "It is no exaggeration to state that no other method within x-ray diagnostics within such a short period of time has led to such remarkable advances in research and in a multitude of applications." The scientists are Allan M. Cormack, Tufts University physicist, and Godfrey N. Hounsfield, an electronic engineer at the British company EMI.

Federal Health Planning Amendments

The recent passage of PL 93-79 has amended PL 93-64, the National Health Planning and Resources Development Act. Listed below are some major conceptual changes.

The role of competition is acknowledged: "Preserving and promoting competition in the health service area" now is listed as a purpose of HSA's. Competition is stressed where it will advance the purposes of "quality assurance, cost effectiveness and access." This is an indication that Congress believes competition is sometimes more effective than regulation in controlling the health care industry.

Priority status is accorded the mental health field: The focus of health planning has been expanded to include mental health. Access to non-institutional forms of treatment is stressed.

The scope of Certificate of Need is broadened: The Certificate of Need section has been expanded to include "major medical equipment." Such equipment is defined as any single piece that costs in excess of \$150,000, excluding equipment in independent clinical labs. This provision applies to major medical equipment in physician's offices if such equipment is used to provide services to inpatients.

SPECIAL REPORT/continued

delegates in presidential nominating conventions beginning with 1980. Already, plans are being formulated for medical political participation in the Republican National Convention to be held in July in Detroit and the Democratic National Convention to be held in New York City in August.

In addition, AMPAC is acutely aware of the importance of congressional reapportionment and redistricting in the make-up of the U.S. Congress in the decade of the 80's.

The people who will serve the Congress in the 1980's will be determined, in large part, by state legislators and governors elected in the 1980 elections. Every 10 years following the US Census, congressional districts and legislative districts are reapportioned and redrawn in most states. According to projected statistics, the state of Michigan will lose at least two congressional districts.

Political activists should prepare for the loss of these districts by getting involved in legislative and congressional races right now in order to have an influence over the redrawing of congressional district lines.

In the 80's AMPAC will continue its efforts to maintain and protect the integrity of the American electoral process. Surveys financed by AMPAC, but conducted by a non-biased survey research firm, show that the majority of the American people oppose using tax dollars to fund congressional campaigns.

However, groups such as Common Cause and others continue to push for taxpayer financing of congressional campaigns. Here are some reasons why AMPAC opposes taxpayer financing of congressional campaigns:

1. Taxpayer financing protects incumbents.
2. Taxpayers do not support the idea of using their tax dollars to fund congressional campaigns.
3. Taxpayer financing turns over the control of elections to bureaucrats.
4. Taxpayer financing erodes the traditional accountability which a congressman must have to his constituents.
5. Taxpayer financing forces the taxpayer to support candidates they do not like and do not want.

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How the Romans delivered medical care along Hadrian's Wall fortifications

By Orville Oughtred, MD, Mt. Clemens



Doctor Oughtred's own photo of the Housesteads Fort's hospital.

Peripatetic MSMS Councilor Orville Oughtred, MD, Mt. Clemens, has prepared another account for *Michigan Medicine* readers of his recent adventures. The following story provides a quick and interesting peek at the medical and living conditions of the Roman legions who built and lived along Hadrian's Wall in England.

In the company of my English cousins I visited a section of Hadrian's Wall in October 1979.

Hadrian's Wall is a series of Roman remains stretched irregularly across England at its narrowest point, a gap dipping through the Pennine Chain called "The Tyne Soloway Gap." Hadrian's Wall is little more than 73 miles long. It is an enduring monument of Roman presence; the Romans came in force to Britain circa AD 43 and remained for nearly 400 years.

Much of the area in Scotland north of the Wall had been conquered by Julius Agricola, Governor of Britain, AD 78-84. Hadrian became Emperor, succeeding Trajan in AD 117. His policy was to consolidate existing Empire frontiers. He visited Britain circa AD 122 and ordered a wall to be built along the already existing Stanegate Road. Stanegate Road was built by Agricola where the east-west communication was easy.

Hadrian's Wall took 10 years to build. The work was supervised by Governor Alus Platorius Nepos.

The construction

On the north side of the Wall, except where the ground is steep, was a great ditch. On the south side was a flat-bottomed ditch with an earth ramp at both ends, called a "Vallum."

Between the Vallum and the Wall a road was built. Along the Wall at every mile was a small fort called a "milecastle," with two turrets erected between each pair of milecastles. At suitable strategic areas along the Wall were 17 forts which were used for garrisons. The original height of the wall was about 15 feet with a parapet of about six feet. The width varies from eight to ten feet.

The garrison of Hadrian's Wall was not formed by the Roman legions. It was formed by smaller units of the regular army known as "cohorts" and "alae," 500 to 1,000 strong, infantry and cavalry battalions. These soldiers were called auxiliary forces. They received full citizenship upon completion of 25 years of service.

The legions including their trained craftsmen built the Wall. Native help was used for driving the oxen carts and moving materials. There were three legions in Britain during the Roman period: the Second

at Caerleon, Sixth at York and Twentieth at Chester. The York and Chester legions had direct access by roads to the wall when needed for defense.

The legion contained nearly 6,000 men, commanded by a senator with the title of legate: Six tribunes were under him. Next in rank were the centurions, 60 to each legion. The auxiliary forces were commanded by prefects or tribunes. The total garrison of the Wall area was 15,000 men.

Physical shape

The units in the various forts engaged in exercise and training so as to be ready at a moment's notice for defense. The training exercise of the legion soldiers was more strenuous than the auxiliary. How many soldiers in the auxiliary units survived and retired after 25 years? As far as the legion soldiers were concerned, one half of the recruits entering at age 18 would be alive at age 42. This was a better life expectancy than the civilian population enjoyed.

The auxiliary soldiers in the forts had a good variety of food: Beef, mutton, goat and pork meats were in good supply from animals around the fort. Milk, cheese, eggs, shellfish, oysters, chicken and other foods were available. There was a good variety of local fruits. There have been no records found of complaints concerning the military diet. The auxiliary was

well clothed. Each soldier had military boots, a heavy woolen cloak, a leather tunic and leather trousers.

The barracks were superior to the civilian dwellings; braziers of charcoal were used for heat. Aqueducts, special drains, brought adequate water supply to the fort. Disposal of waste water was also adequate.

More soldiers died from disease than from wounds. The Roman development of bathing and sanitation aided in the prevention of epidemics. The forts contained hospitals available for the sick and wounded.

Medical arrangements

There were three categories of medical attention. There were the short service commissioned medical officers, there were career medical officers of centurion rank and finally there were the bandagers and order-

lies who took care of the wounded in the field and the sick in the hospitals. There were also the equivalents in veterinary work. The dead were removed early from the compound, properly buried or cremated.

The hospital was the special responsibility of the prefect. Instruments of iron and bronze have been found in considerable numbers. Some are quite modern in appearance, such as osteotomes, periosteal elevators and iron scalpels. Army doctors were quite skilled surgically. Amputations were done; artificial legs have been found in the Roman graves. Wounds were sutured using flax and woolen thread. Anesthesia was pretty well unknown. Drugs from mandrake and poppy seed were used. Medical remedies were primitive and revolting; for example, Pliny's List:

- 1 — Hot turnips to cure chilblains and gout.
 - 2 — Garlic cooked in milk for breathing problems.
 - 3 — Mint mixed with mustard for syncope.
 - 4 — Mustard used as a gargle for stomach problems.
- It was stated that most medicines were better when mixed with wine and honey.

Julius Caesar conferred citizenship upon doctors to aid recruitment. Many of the doctors were of Greek origin and many went into private practice after leaving the army. It is recorded some of the men became Roman specialists; were fierce and unscrupulous, and collected thousands of dollars for their services. The Hippocratic physician was a craftsman who sold his services to whomever was able to pay for them.

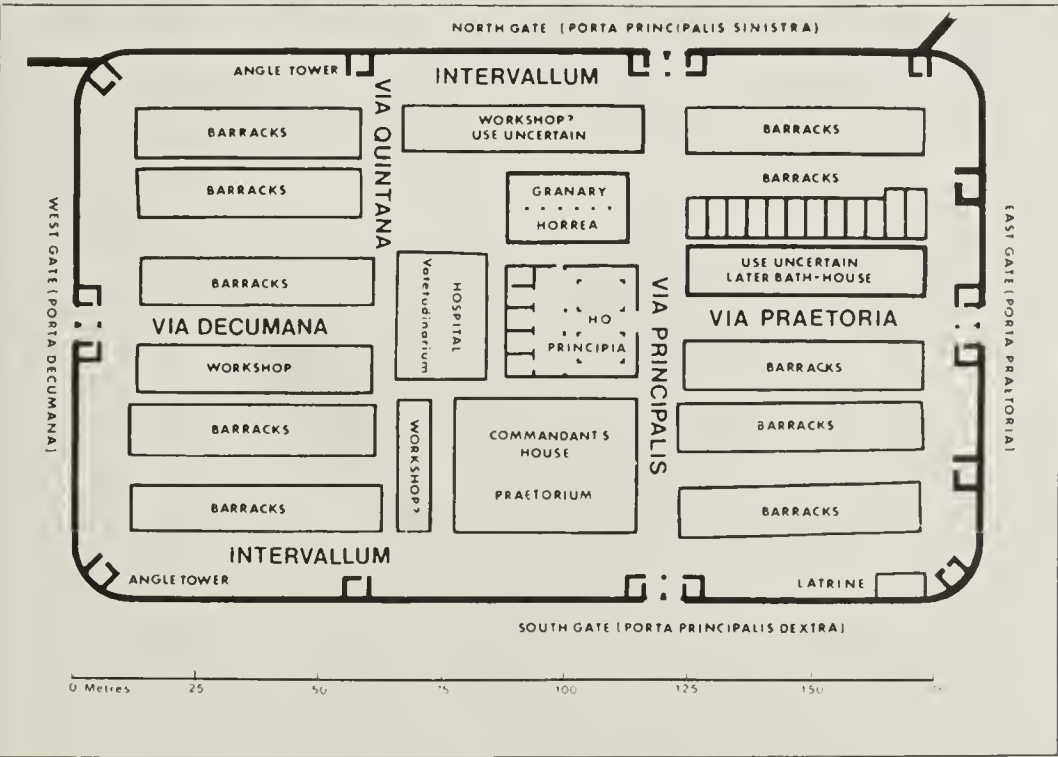
Personal view

My cousins and I visited a mid-portion of the Wall in an area known as "Housesteads Fort." To reach this area requires a strenuous walk down a deep slope, through a wet valley and up another slope. Prior to our arrival at the car park on Stanegate Road, we regaled ourselves at the "Twice Brewwed Tavern," with hot venison meat pies and pints of Newcastle ale. My companions are used to walking and were in much better shape than I. Excuses for resting along the path were necessary.

The Wall in these parts is built running East and West for many miles on the highest part of a quartz dolerite outcropping called "Whin Sill." The fort is astride the Wall on its north side. The remains include fort walls, gateways, interval towers, two barracks buildings with several more to be excavated, a hospital, commanding officer's residence, headquarters building, two granaries and a latrine block. Farther out beyond the East Gate is the military bathhouse and water tanks. Most of the forts were built to follow the standard plans of Roman times.

The Fort of Housesteads (Vercovivium) is splendidly situated on a precipice guarding one of the easiest ways through the dolerite ridge at Knag Burn. The Fort covered five acres and housed 1,000 soldiers. The town outside the Fort covered 10 acres or more.

Artist's renderings of the Housesteads Fort



HADRIAN'S WALL/continued

The Headquarters Building (principia) occupies the central position in the Fort, on the main north-south road (via principalis). The entrance step is worn down in the middle by the thousands of footsteps that must have passed over it.

West of the Headquarters Building is the hospital. It is a square building with a range of rooms surrounding a central open courtyard. Doctor Anicius Ingenuus died at Housesteads at the age of 25. His tombstone is in the museum at Newcastle, as the Roman army medical service was an important one.

The granaries were immediately north of the Headquarters Building. These contained several upright pillars which held the floor up to allow air to circulate underneath.

South of the Headquarters Building is the spacious residence of the commanding officer with four ranges of rooms and a separate bath-suite.

Sanitary conditions

At Housesteads there is a large, well preserved communal latrine. Timber seating covered a deep sewer, sufficient for 20 men at a time. There was a narrow channel of water running along the edges of a central platform which held the sponges which were used as a substitute for toilet paper. These were washed in the running water. Two great stone basins were used for washing of hands. The sewers were flushed with water from collection tanks and by inflow from the fort drains.

The military bathhouse is 200 yards from the East Gate. Its site was determined by the proximity of good water supply and drainage. Several areas were present in the bathhouse such as hot plunge bath, cold plunge bath, hot moist room and dry hot room. Elaborate heating ducts and drains were constructed in the floor.

The bather covered his body with olive oil. The perspiration loosened the dirt which was scraped off with a curved knife known as a strigel. The bathhouse was also a social club. Cups of dice have been found in them. In another fort along the wall, it was found that one set of dice was loaded. In one of the wells, coins were found along with a forger's mold.

Story's end

The country fell into chaos at the beginning of the fifth century; a fearful period of war and lawlessness. The Anglo-Saxons destroyed everything in their path. The skills of building, engineering, administration and the civilization of Rome was forgotten within two generations.

Dark times remained until the seventh century. St. Wilfred began his Church at Hexham, circa AD 675. He used the abandoned town of Corstopitum as his quarry. The author visited this Abbey. For centuries the Wall was an easy source of building materials.

I believe the deeply grooved front doorsteps at the Housesteads Fort Headquarters building, carved by thousands of footsteps, now seen by a few curious observers, illustrate what can happen to an advanced civilization when law, order and leadership disappear.

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Brief Summary

INDICATIONS: For the prevention and treatment of nocturnal recumbency leg muscle cramps, including those associated with arthritis, diabetes, varicose veins, thrombophlebitis, arteriosclerosis, and static foot deformities.

CONTRAINDICATIONS: Because of the quinine content, Quinamm is contraindicated in women of childbearing potential, in pregnancy, in patients with known quinine sensitivity, and in patients with glucose-6-phosphate dehydrogenase deficiency. Hemolysis (with the potential for hemolytic anemia) has been associated with a G-6-PD deficiency in patients taking quinine.

PRECAUTIONS: Thrombocytopenic purpura may follow the administration of quinine in highly sensitive patients. Recovery will follow withdrawal of the medication. Cinchona alkaloids, including quinine, have the potential to depress the hepatic enzyme system that synthesizes the vitamin K-dependent factors. The resulting hypoprothrombinemic effect may enhance the action of warfarin and other oral anticoagulants.

ADVERSE REACTIONS: Aminophylline may produce intestinal cramps in some instances, and quinine may produce symptoms of cinchonism, such as tinnitus, dizziness, and gastrointestinal disturbance. If ringing in the ears, deafness, skin rash, or visual disturbances occur, the drug should be discontinued.

DOSAGE AND ADMINISTRATION:

1 tablet upon retiring. When necessary, 1 additional tablet may be taken following the evening meal.

Product Information as of September, 1977

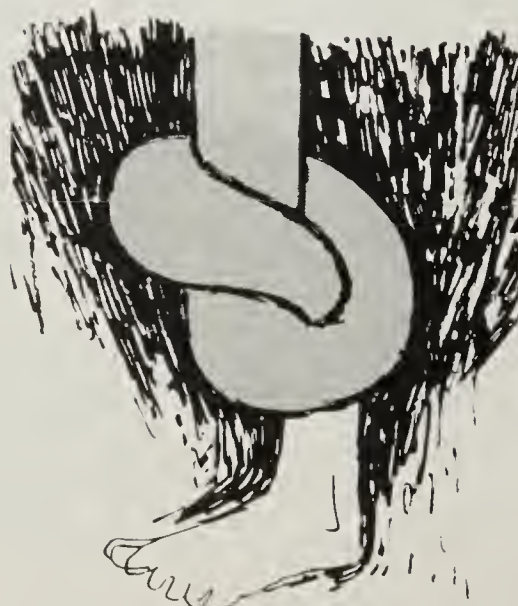
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Please see last page for brief summary, including warnings, precautions, and adverse reactions.

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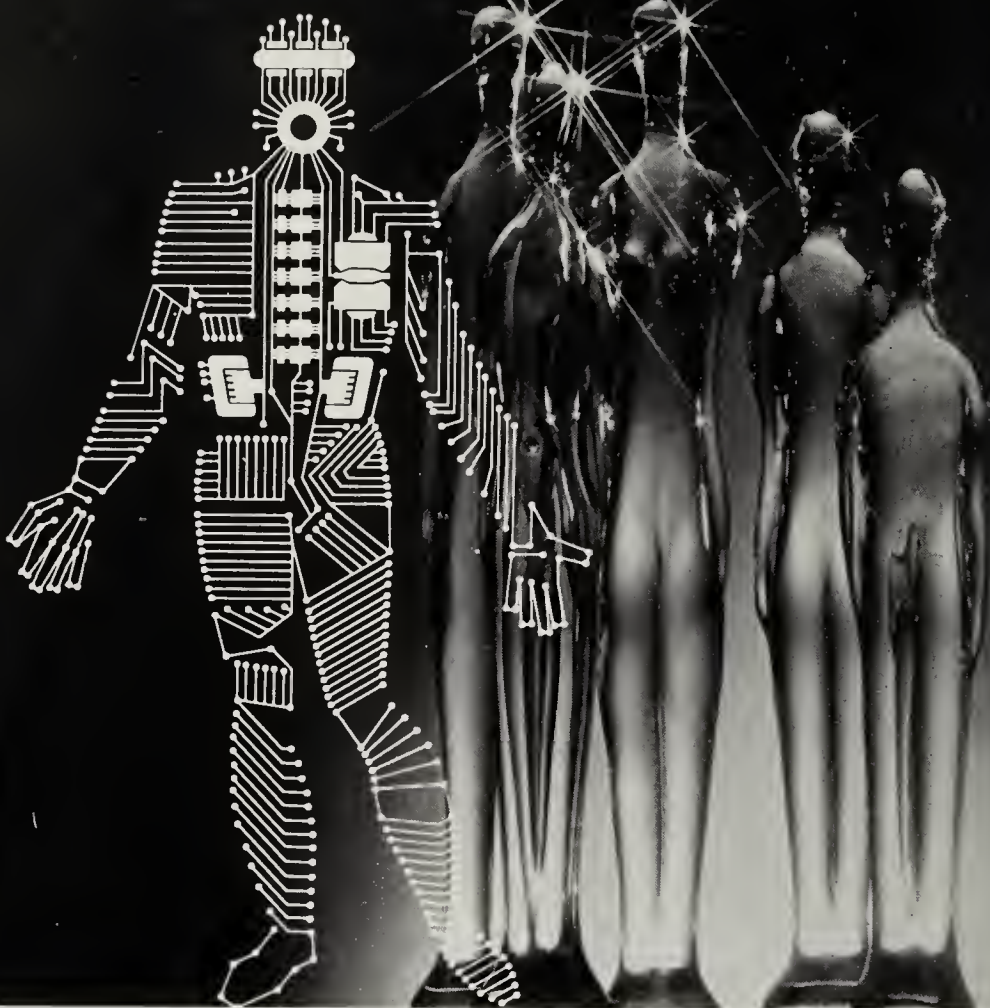
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- Preserves kidney blood flow.

Most common side effects are dry mouth, drowsiness, and sedation which generally tend to diminish with time.

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(clonidine hydrochloride)
Tablets of 0.1, 0.2, 0.3 mg

Indication: The drug is indicated in the treatment of hypertension. As an anti-hypertensive drug, Catapres (clonidine hydrochloride) is mild to moderate in potency. It may be employed in a general treatment program with a diuretic and/or other antihypertensive agents as needed for proper patient response.

Warnings: Tolerance may develop in some patients necessitating a reevaluation of therapy.

Usage in Pregnancy: In view of embryotoxic findings in animals, and since information on possible adverse effects in pregnant women is limited to uncontrolled clinical data, the drug is not recommended in women who are or may become pregnant unless the potential benefits outweigh the potential risk to mother and fetus.

Usage in Children: No clinical experience is available with the use of Catapres (clonidine hydrochloride) in children.

Precautions: When discontinuing Catapres (clonidine hydrochloride), reduce the dose gradually over 2 to 4 days to avoid a possible rapid rise in blood pressure and associated subjective symptoms such as nervousness, agitation, and headache. Patients should be instructed not to discontinue therapy without consulting their physician. Rare instances of hypertensive encephalopathy and death have been recorded after cessation of clonidine hydrochloride therapy. A causal relationship has not been established in these cases. It has been demonstrated that an excessive rise in blood pressure, should it occur, can be reversed by resumption of clonidine hydrochloride therapy or by intravenous phentolamine. Patients who engage in potentially hazardous activities, such as operating machinery or driving, should be advised of the sedative effect. This drug may enhance the CNS-depressive effects of alcohol, barbiturates and other sedatives. Like any other agent lowering blood pressure, clonidine hydrochloride should be used with caution in patients with severe coronary insufficiency, recent myocardial infarction, cerebrovascular disease or chronic renal failure.

As an integral part of their overall long-term care, patients treated with Catapres (clonidine hydrochloride) should receive periodic eye examinations. While, except for some dryness of the eyes, no drug-related abnormal ophthalmologic findings have been recorded with Catapres (clonidine hydrochloride), in several studies the drug produced a dose-dependent increase in the incidence and severity of

The usual starting dose of Catapres is 0.1 mg at breakfast and 0.1 mg at bedtime. Some patients may benefit from a starting dose of 0.1 mg at bedtime.

Usual daily dose range—0.2—0.8 mg

Maximum daily dose—2.4 mg

Doses as high as this have rarely been employed.

For optimal results, the dose of Catapres must be adjusted according to the patient's individual blood pressure response.

spontaneously occurring retinal degeneration in albino rats treated for 6 months or longer.

Adverse Reactions: The most common reactions are dry mouth, drowsiness and sedation. Constipation, dizziness, headache, and fatigue have been reported. Generally these effects tend to diminish with continued therapy. The following reactions have been associated with the drug, some of them rarely. (In some instances an exact causal relationship has not been established.) These include: Anorexia, malaise, nausea, vomiting, parotid pain, mild transient abnormalities in liver function tests; one report of possible drug-induced hepatitis without icterus and hyperbilirubinemia in a patient receiving clonidine hydrochloride, chlor-thalidone and papaverine hydrochloride. Weight gain, transient elevation of blood glucose, or serum creatine phosphokinase; congestive heart failure, Raynaud's phenomenon; vivid dreams or nightmares, insomnia, other behavioral changes, nervousness, restlessness, anxiety and mental depression. Also rash, angioneurotic edema, hives, urticaria, thinning of the hair, pruritus not associated with a rash, impotence, urinary retention, increased sensitivity to alcohol, dryness, itching or burning of the eyes, dryness of the nasal mucosa, pallor, gynecomastia, weakly positive Coombs' test, asymptomatic electrocardiographic abnormalities manifested as Wenckebach period or ventricular trigeminy.

Overdosage: Profound hypotension, weakness, somnolence, diminished or absent reflexes and vomiting followed the accidental ingestion of Catapres (clonidine hydrochloride) by several children from 19 months to 5 years of age. Gastric lavage and administration of an analeptic and vasopressor led to complete recovery within 24 hours. Tolazoline in intravenous doses of 10 mg at 30-minute intervals usually abolishes all effects of Catapres, (clonidine hydrochloride) overdosage.

How Supplied: Catapres, brand of clonidine hydrochloride, is available as 0.1 mg (tan) and 0.2 mg (orange) oval, single-scored tablets in bottles of 100 and 1000. Also available as 0.3 mg (peach) oval, single-scored tablets in bottles of 100.

For complete details, please see full prescribing information.

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Ophthalmology fights back!

By Philip C. Hessburg, MD, Grosse Pointe Park, and
Justin L. Moran, East Lansing

The following is the first of a two-part series to describe the aggressive drive of Michigan ophthalmologists to protect their specialty from intrusions into the field by the state's optometrists. This first part provides the background for the struggle. The second part, to appear in the March *Michigan Medicine*, will describe the ophthalmologists' advertising and media campaign to educate the public to its choices.



"When an MD or osteopath prescribes your glasses, you get the finest eye care possible," reads the headline on a public service ad featuring this photo. The ad is sponsored by Medical Eye Services of Michigan, Inc.

Ophthalmology is the first medical specialty to be forced into a pitched battle for the right to survive. And the battle is probably fiercest in Michigan, where more than 300 ophthalmologists (MDs and DOs), practice.

Several factors have combined in Michigan to severely threaten the general ophthalmologist's practice.

Major factors

The first is the success of optometry's national efforts over the past 25 years to win acceptance of their position: that the optometrist should be the primary provider of "vision care" and that ophthalmologists should provide only secondary and tertiary eye care upon referral from an optometrist. This position has achieved some acceptance among health care planners.

In an effort to add credibility to

Doctor Hessburg is president of the Michigan Ophthalmological Society, and Mr. Moran is director, MOS public information and communications.

their position, optometrists across the country have sought state legislation giving them the right to use diagnostic pharmaceutical agents and to prescribe medication for the treatment of disease. They have been quite successful in this effort and now enjoy the right to use diagnostic drugs in more than 20 states and to prescribe therapeutic drugs in several states.

Optometrists have not obtained either right in Michigan yet, but they may try to do so in the future. An earlier attempt, in 1966, to enact an optometric drug bill in Michigan failed.

Ophthalmology vigorously opposes the granting of any right to optometrists to use or prescribe drugs. Optometrists have not attended medical school and do not have a medical background. Therefore, they should be very limited practitioners, ophthalmologists believe.

The second factor contributing to the threat to ophthalmology is the increasing popularity of vision care fringe benefit programs. Because of the ability of major unions to successfully bargain for new and expanded fringe benefits here, Michigan is in the forefront of the de-

velopment of vision care plans. These benefit programs provide for periodic eye examinations and for payment for spectacles when needed.

Unfortunately, some vision care plans are "captive" programs, providing payment only for examinations by optometrists who are employees of one optometric establishment or chain. Many other plans purport to provide a choice between ophthalmological or optometric examinations but pay a maximum fee for a routine examination which is grossly inadequate compensation for a complete medical eye examination.

Blue Cross Blue Shield of Michigan administers the vision care plans for Ford Motor Company and Chrysler Corporation employees. These plans provide for substantial participating/non-participating differentials. Because most ophthalmologists believe that such differential reimbursement interferes with the patient's freedom of choice among health care providers, few of them participate in that organization's vision care plans.

In contrast, the General Motors plan is administered by Metropolitan

OPHTHALMOLOGY/continued

Life Insurance Company. Most Michigan ophthalmologists consider the General Motors plan to be a good one which treats their patients fairly.

Major challenge

The efforts of optometrists to acquire the right to function as physicians, and the development of inadequate vision care plans have been serious challenges to ophthalmology. However, the entry of major corporations into the vision care field constitutes, by far, the greatest challenge faced by ophthalmology.

The basic business of these corporations is the manufacture and sale of eyeglass frames and lenses. However, they have found that the combined offer to "patients" of an optometric examination and eyeglasses is the best marketing technique.

Moreover, the profitability of frames and lenses can be so great in adequate volume that the optometric examination can be offered on a "break-even" basis when competition requires.

Corporate optometry has been

enormously successful, particularly in Michigan. Traditionally, ophthalmologists and optometrists have shared routine eye and vision examinations about equally. During the first two years of the auto company vision care plans, however, optometrists are said to have performed seven out of 10 examinations while ophthalmologists performed only 3 out of 10. Most significantly, corporate optometric establishments are said to have performed 70 percent of the optometric examinations — or one half of all examinations! Clearly, it pays to advertise "professional" services.

Continuation of current trends will have a severe impact on Michigan's ophthalmologists. A great majority of the general ophthalmologist's patients seek appointments for complete medical eye examinations without suspecting pathology even though a substantial percentage are found to have medical or surgical eye problems.

If ophthalmologists see only those patients referred to them by non-medical practitioners, only a handful of specialists will be left with economically viable practices.

And the economic consequences for physicians, while severe, do not represent nearly as great a problem as the deterioration in public health standards which might follow from such non-medical triage.

Aggressive action

Michigan ophthalmology has taken aggressive action to preserve the standards of eye care in the state. The Michigan Ophthalmological Society has retained a legislative advocate ever since it won the first optometric drug bill fight in 1966. It will not be without friends and allies in the Michigan legislature if the issue comes up again.

In recognition of the realities of the current political scene, the Ophthalmologists Political Action Committee (O-PAC) has become one of the most active and best supported professional PACs in the state. O-PAC conducts a joint fund-raising effort with MDPAC and AMPAC.

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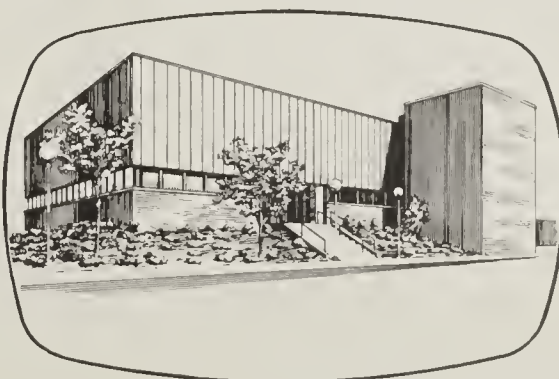
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Physicians' suggestions for UAW/auto talks now part of contract recommendations

By B. J. Iserman, DBA, Professional Organization Consultant and Liaison
Blue Cross/Blue Shield of Michigan



Whatever happened to the suggestions Michigan physicians made in 1978 for Blue Cross Blue Shield medical services benefits to be incorporated in 1979-80 auto company-union contracts?

Michigan Medicine sought a report from the Blues themselves as to the outcome of those physicians' suggestions. The following is their report:

In mid-1978, Blue Cross and Blue Shield of Michigan sought assistance from MSMS and others in developing a wide variety of proposals for consideration by the UAW international union and auto manufacturing employers.

Historically, minor misunderstandings between MSMS and the Blues have caused a small schism of credibility on the part of both. This new call for assistance presented the opportunity for better understanding.

Medical community

The prime goal of the project was to solicit recommendations, suggestions and proposals from the whole of the medical community. Recommendations could modify benefits and/or administration as well. They would be coming from providers of medical services such as MSMS and other medical and paramedical elements currently incorporated in the Blues contract. These recommendations would subsequently be molded together by the Blues marketing department, and categorized by benefit group.

The Blues had undertaken a project of major proportions. Nevertheless, MSMS agreed to work with the Council of Specialty Societies to coordinate the suggestions of the specialties as well as those of individual MSMS members.

Lee B. Stevenson, MD, president of the Specialty Societies Council, invited the Blues representatives to express themselves directly to the Specialties Council membership. The Specialties Council agreed it was an opportunity to be heard.

The decision of the Council was to seize the opportunity and return in 60 days with its report. It was mutually agreed that all reports would be channeled through MSMS staff.

Mr. Richard Campau functioned as the coordinator for the project for MSMS, and B. J. Iserman, DBA, represented Blue Cross and Blue Shield of Michigan.

A wide variety of recommendations was assembled and reviewed, although issues of cost containment and improved service delivery took priority. All issues were categorized into two major groups — benefit changes and administrative issues. After analysis by the MSMS staff, the entire package was forwarded to Blue Cross and Blue Shield.

When this document was combined with recommendations of other providers of health care, the final product exceeded 450 pages. By eliminating duplicate information not pertinent to the auto contract, the Blues administrative staff reduced the document to 120 pages. It was then bound and forwarded to the auto negotiating parties. At no time

did the Blues infer or guarantee that proposals of any provider group would be automatically included in the contract or even discussed at the bargaining table. The basis for the interest of both auto and Blues parties was to maximize the medical knowledge and expertise of the negotiating parties by improving the flow of information. The project accomplished that end.

Better understanding

Numerous position papers on a variety of issues have since been drafted from the material supplied by the medical community. Blue Cross and Blue Shield has benefited from this diversified information bank, and the project has resulted in a better understanding by those individuals who negotiate our services.

Auto negotiations are now concluded, and some of the benefits agreed on are recognizable as recommendations made by health providers. Others are conspicuous by their absence. However, the cooperative effort by BCBSM and Michigan physicians was a rewarding exercise, mutually beneficial, and should be repeated. The best interests of patients or customers are served more completely and efficiently when major medical elements work together. And the story is not over for 1979.

Ninety-seven administrative issues, those issues that are not negotiated, remain to be resolved. Blue Cross and Blue Shield has made a commitment to its provider public that it will respond to each identified issue through official channels.

If you can read these words easily, it means that your eyesight is probably good—maybe even 20/20. But it doesn't mean that your eyes are healthy. Only a Medical Doctor or a Doctor of Osteopathy who is an Ophthalmologist can tell you that. Because only an Ophthalmologist can diagnose and treat all eye disorders—from poor vision to serious brain diseases. Be sure your benefit program permits you to choose eye care by an Ophthalmologist. □ Then see one, and see."



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Important to distinguish wastes of nuclear plants, biomedicine

By Charles R. Downs, Special to Michigan Medicine

Concern about disposal of low-level radioactive waste is a national as well as a Michigan problem. According to a recent issue of *AMA News*, the AMA is urging the federal Nuclear Regulatory Commission to promote the creation of burial sites throughout the nation and to clearly differentiate between low-level and high-level wastes in its regulations.

At any given time, medical and research laboratories in Michigan are only a few weeks away from the threat of a complete shutdown of all diagnoses, treatments and experiments which produce any amount of radioactive waste, no matter how small or how low the level of radioactivity.

Preposterous? Yes. Impossible? No.

Only three states — Washington, Nevada and South Carolina — currently have disposal sites for low-level radioactive waste. And, for political and environmental reasons, all three states have shut down their sites for various intervals in recent months. And all three could do so again, at any time.

Little recourse

If that happens, there is just enough temporary storage space at Michigan hospitals and universities for about two months' accumulation. When that space is filled, all nuclear medicine and all research involving radioactive isotopes will have to stop.

In Michigan there would be little recourse. Even if state laws, which specifically forbid any kind of radioactive waste disposal site, were changed, it would require at least several months to select and prepare a suitable site.

Activities that would be affected would include such relatively routine procedures as blood tests for serum thyroxin, cancer work-ups, and treat-



Photo courtesy: Prism Calendar of St. Joseph Mercy Hospital.

ment of hyperthyroidism. In addition, tens of millions of dollars worth of research and teaching programs, principally at Michigan State University, the University of Michigan and Wayne State University would suddenly cease.

Concerned about this prospect, Howard H. Dworkin, MD, chief of the Department of Nuclear Medicine at William Beaumont Hospital in Royal Oak, asked colleagues from other hospitals and representatives of state universities to a meeting at Beaumont.

He learned that his concern was shared when 75 physicians, radiological safety officers and other nuclear scientists turned up to hear experts from Duke University, New England Nuclear Corporation, MSU, U of M, the Michigan Department of Public Health (MDPH), Henry Ford Hospital and Beaumont Hospital discuss the problem from their respective viewpoints.

Michigan unprepared

"My principal reason for calling the meeting," said Doctor Dworkin, "was that I felt Michigan, which currently outlaws burial of any kind of radioactive materials, has to confront the problems of low-level waste.

"My opinion, and, I think, the consensus of the meeting, is that Michigan, either singly or jointly with neighboring states, is going to have to come up with a long-term plan for safe,

environmentally sound disposal of low-level radioactive wastes.

"I think the Department of Public Health is aware of the problem and is actively studying the state's options. But other state officials, particularly our legislators, are going to have to understand the problem, too."

Allied with Doctor Dworkin and his medical colleagues are researchers at state universities.

"It is internally inconsistent," John E. Cantlon, PhD, MSU vice president for research and graduate studies recently stated, "for states to be encouraging medical procedures and biological research which require radiation and at the same time not providing for in-state disposal of the wastes produced by that research."

Public fear

One of the obstacles to solution of the problem appears to be public fear resulting from the continuing nuclear energy debate.

"It is very important," said Doctor Dworkin, "to distinguish between the radioactive wastes from nuclear plants and the wastes from biomedical activities. There is a millionfold or even a billionfold difference."

Some of the experts in the Beaumont conference expressed hope that the current dilemma will lead to reform of federal regulations governing the handling of low-level radioactive wastes as well as the creation of new disposal sites.

They noted that the law requires stringent, expensive procedures even when waste materials are less radioactive than a wrist watch.

Disposal problems are particularly acute at university research laboratories where large numbers of rats and other research animals must be packed in barrels and shipped thousands of miles.

This is necessary even when, as Nobelist Rosalyn Yalow has pointed out, the experimental animal is less radioactive than a normal human.

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Michigan's government and you, doctor

The Michigan Department of Social Services

By Sherry Nolte Wellman, MSMS Government Agencies Liaison

Part three of a series to help Michigan physicians better understand the relationship of state government to medical practice.

The Michigan department of Social Services is a multi-service agency which administers a broad range of financial assistance, medical assistance, and social services programs under several funding sources. Approximately 1,000,000 persons each month receive one or more of the services provided by the Department of Social Services. Director of the department is John T. Dempsey, PhD.

The major financial assistance programs are Aid to Families with Dependent Children (AFDC), General Assistance (GA), Food Stamps, and Emergency Assistance, with an average payment of about \$100 per recipient each month. Medical Assistance is provided at an average monthly cost of approximately \$200 per recipient.

The 1979-80 appropriation for Social Services authorizes \$2.6 billion for the fiscal year. Approximately 50 percent of this is federal funds and 50 percent state funds. Approximately 84 percent of the funds are spent for grants in the AFDC, Medicaid, GA, Day Care, Foster Care and Adult Home Help programs. Departmental salaries account for 10 percent of the funds.

Medical Services **— Paul M. Allen, Director**

The Medical Services Administration of the Department of Social Services is directly responsible for the administration and management

of the Michigan Medical Assistance Program (Medicaid).

Medicaid is a state-operated program, paid for by a combination of state and federal money, which makes health care available to residents of Michigan who would otherwise not be able to afford adequate medical care. MSA is also the fiscal agent for the state's Crippled Children Program administered by the Michigan Department of Public Health.

Medicaid services are available to nearly 90,000 persons, or about one out of every 10 residents of Michigan. Of individuals eligible for Medicaid, 10 percent are aged, 11 percent are blind or disabled, 54 percent are children, and 25 percent are parents with one or more dependent children. Nearly 30,000 of those receiving benefits are residents of nursing homes and have an average age of 82 years. Medicaid accounts for almost one-half of the total appropriation to the Department of Social Services.

Because Michigan physicians are in more direct contact with the Medicaid program than the other services offered by the Department, it is worthwhile to highlight three of the divisions within the Medical Services Administration which have the most relevance for Medicaid practitioners and providers.

Office of Program Development and Reimbursement **— Steven Scheer**

As a support operation for the Medical Services Administration, this office is responsible for providing evaluative assistance through participation in the development of

new or amendatory Medicaid and health care legislation; for the development and analysis of Medicaid reimbursement levels and methodology; for conducting research and analysis of new or modified policies and service delivery impacts and relationship to federal and state laws and regulations; for providing evaluation of existing policy and coverages and preparing special studies for use in program management, budget and the legislative process. The office also negotiates with providers to establish mutually acceptable reimbursement programs and to coordinate their implementation.

Bureau of Medicaid Information and Policy Development **— Vernon Smith, PhD**

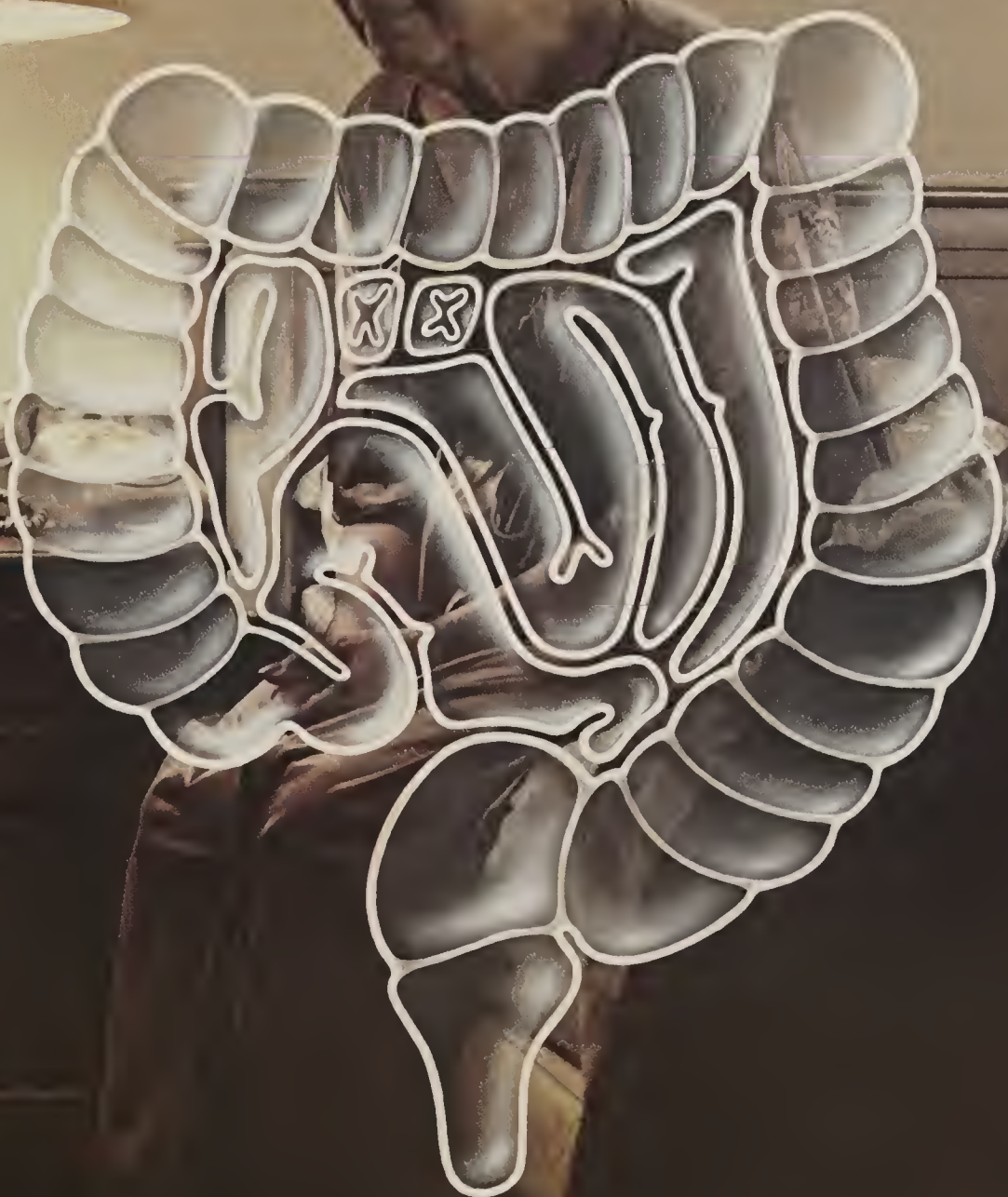
This Bureau is responsible for the development and promulgation of Medicaid policy, for the enrollment of medical practitioners and providers and for communications between the Medicaid program and providers, news media and the general public.

The Bureau is comprised of three divisions: (1) Medicaid Policy, (2) Medicaid Information, and (3) Long Term Care Certification. Duties of these units are to develop, implement and assure consistency in Medicaid program policy; assure that the state plan is in compliance with federal regulations; provide proper legal base for Medicaid programs through establishment of appropriate administrative rules; coordinate all PSRO related activities; and respond to the daily information requirements of enrolled providers. The Bureau is also responsible to instruct enrolled

continued on page 78

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What medical education is doing to provide physicians for Michigan

By Robert K. Richards, PhD, and Ann Maxwell Eward, Grand Rapids

Since the passage of Medicare and Medicaid in 1965 there has been increasing public concern about medical education.

Initially this concern focused on sharply increasing the supply of physicians and other health professionals to meet public demands for access to health care.

Since the mid-1970's, however, there has been a growing awareness that adequate numbers of doctors alone will not assure access to care without attention to their specialty choice and their decision regarding geographic location of practice.

Achieving a desired specialty and geographic distribution of physicians is a difficult task in the democratic society that prizes individual freedom of choice. Therefore, the public, through government, has turned to medical education as the mechanism to influence the choices made by the men and women now entering medicine.

How has medical education responded to this societal mandate?

Very well, in terms of adequate numbers. Nationally, 23 new medical schools have been opened since 1969 and pre-existing schools have increased their enrollments. The number of graduates has almost doubled during the decade and further increases are projected in the 1980's. In addition to these changes in medi-

cal education there has been a vast expansion of other health professionals including physician extenders such as physicians' assistants and nurse practitioners.

Michigan's medical schools have made a number of efforts to encourage students to consider primary care

specialty training and eventual practice in underserved areas of the state.

Under the assumption that physicians who grew up in Michigan will be more likely to practice in the state, the four schools fill over 90 percent of their classes from Michigan residents. Many of these students

Table — Medical education demographics

National Data, Medical Schools	1969	1979
Number of medical schools (MD only)	99	122
Number of graduates	8,059	15,123
Women in entering class	9%	25%

- 8.3% of the 1977-78 entering class were from under-represented minorities (Black American, American Indian, Mexican American, Puerto Rican — U.S. Mainland).¹
- 50% of 1977-78 medical school applicants stated that their desired future practice location was a town or smaller city (under 50,000).¹

Michigan Medical Schools	1969	1979
Number of medical schools (MD & DO)	3	4
Number in entering class	389	724

- 93% of admitted students are from Michigan.
- 10 students are admitted biennially to MSU-CHM's Upper Peninsula Medical Education Program.
- 200 physician-preceptors and 350 medical students participate annually in the Cooperative Primary Care Preceptorship program.
- 60% of 1979 graduates stayed in Michigan for Graduate Medical Education.
- Over 50% of graduating students selected residencies in primary care specialties (family practice, internal medicine, pediatrics and obstetrics and gynecology).

Graduate Medical Education in Michigan

- As of 1978 there were 1,423 first year house officer positions (MD & DO) in Michigan and 1,252 (88%) of them were filled.²
- 58% of first year residents in Michigan are pursuing training in Primary Care specialties.²

¹Travis L. Gordon, Study of U.S. Medical School Applicants, 1977-78 *Journal of Medical Education* September, 1979.

²Survey of House Officers in Graduate Medical Education in Michigan, 1978, Statewide House Officer Training System, Inc., August, 1979

Doctor Richards is assistant dean and associate professor at Michigan State University College of Human Medicine and is executive vice president of the Grand Rapids Area Medical Education Center. Ms. Eward is a doctoral candidate at Michigan State University and has served an administrative internship at GRAMEC.

MEDICAL EDUCATION/continued

have personal ties to medically underserved areas of the state which could enhance the probability of their returning to the area as practicing physicians.

Great example

An outstanding example of such an effort is the Upper Peninsula Medical Education Program of Michigan State University College of Human Medicine which admits biennially 10 students with UP "roots." Most of their education occurs in Marquette and Escanaba and emphasizes primary care in ambulatory settings. Seven of the first 10 graduates of this program have selected primary care residencies with a stated intent to return to the UP for eventual practice.

Other efforts, especially the National Health Service Corps, provide financial aid to medical students in exchange for an agreed-to period of practice in an underserved area following their training. Underserved areas can be urban or rural, as well as a special population such as Indians on a reservation or individuals in a prison or mental hospital. Nationally, over 4,500 MD and DO students and residents have current NHSC "pay-back" obligations. Their eventual assignments to physician-short areas will provide temporary access to med-

ical care and could lead to their decision to continue practice in the underserved area.

Under the assumption that medical students who take residencies in Michigan will be more likely to remain in the state for practice, each of the MD schools sponsors annual Michigan Hospital Days with the Michigan Association for Medical Education. Hospital Days encourage third and fourth year students to consider teaching hospitals in Michigan for their graduate training. These efforts are achieving some success. Sixty percent of 1978 graduates stayed in Michigan for their residencies, which is a 10 percent increase over 1972. The number of students who leave the state for residency is more than offset by graduates from other states and countries who come to Michigan for residencies.

Only half

Completion of medical school is only half of a physician's formal education. Virtually all MD graduates now complete residencies of at least three years' duration. Residency programs are provided by larger teaching hospitals and only some are related to medical schools. Since policies and practices in graduate medical education significantly influence physicians' specialty and location decisions, a cooperative effort between medical

schools and teaching hospitals is essential. Michigan is fortunate to have several organizations which foster such cooperation, including the Michigan Association for Medical Education and the Statewide House Officer Training System.

Federal policy makers have established a goal of at least 50 percent of residency positions in primary care specialties, which are defined as family practice, internal medicine, pediatrics and, in Michigan, obstetrics and gynecology. In 1978, 58 percent of first year residents in Michigan hospitals were in training programs in primary care. State financial support for the creation and expansion of family practice residencies, including a new program in the Upper Peninsula, has been a key factor in achieving this goal in Michigan.

Overall, this is an impressive record of response by medical education and government in meeting the public demand for more physicians and for primary care training. Medical education is a lengthy process, seven years at the minimum, so there is a long lag between changes and outcomes. If public access to care is to be assured, we will need continued efforts by medical schools and teaching hospitals adequately supported by the public and legislature.

DSS/continued

providers on proper billing procedures through billing seminars; review and resolve Medicaid billing problems, design and distribute all published materials including forms, manuals, program change notifications; and conduct quarterly liaison meetings with the organization representing each provider group.

Bureau of Health Services Review — Robert Levin, DDS

The Bureau of Health Services Review is responsible for the surveillance review and monitoring of proposed services and services rendered to Medicaid recipients by providers of health care, and the certification and enrollment, monitoring and reporting of specific health care institutions.

The Bureau is comprised of a Professional Services Unit and four operating divisions: (1) Prior Authorization, (2) Medicaid Monitoring,

(3) Dental, and (4) Concurrent Review.

The purpose of this operation is to assure that health services and supplies, whether provided or proposed to be provided, are actually medically needed, all alternatives have been given consideration, the proposed services and supplies conform to commonly accepted standards of the profession involved, and the services are appropriate to the recipients' level of care.

MSMS liaison

The MSMS Medicaid Liaison Committee, chaired by David Siegel, MD, Lansing is the primary vehicle for maintaining contact with and impacting the Medicaid program. The committee has been in existence since 1972 when it was called into being by Governor Milliken to resolve a dispute regarding a proposed physician participation agreement for Medicaid.

The purpose of the committee is to resolve individual physician's problems with Medicaid payments and procedures, if possible, and negotiate with state government on major policy issues of the Medicaid program on behalf of Michigan physicians. The committee was given permanent status by the House of Delegates in 1973.

Members of the committee meet quarterly with key officials from the Michigan Department of Social Services, Michigan Department of Public Health, and the Office of Health and Medical Affairs.

MSMS physicians who serve with Doctor Siegel on the Medicaid Liaison Committee are John W. Coles, MD, Mt. Pleasant; Thomas M. Flake, MD, Detroit; James D. Johnston, MD, Traverse City; Henry A. Kallet, MD, Jackson; John L. Loomis, MD, River Rouge; Gerald H. Mandell, MD, Detroit; Robert J. Toteff, MD, Saginaw; and Allen F. Turcke, MD, Flint.

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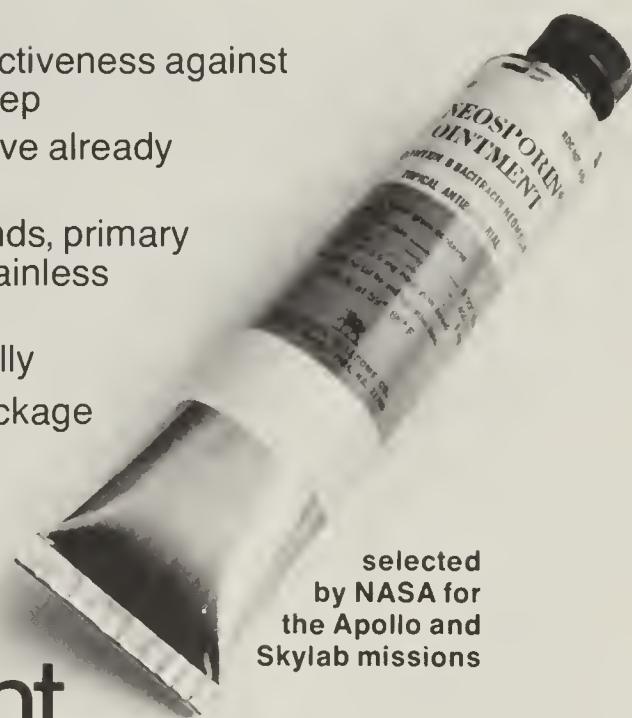
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When using neomycin-containing products to control secondary infection in the chronic dermatoses, it should be borne in mind that the skin is more liable to become sensitized to many substances, including neomycin. The manifestation of sensitization to neomycin is usually a low grade reddening with swelling, dry scaling and itching; it may be manifest simply as a failure to heal. During long-term use of neomycin-containing products, periodic examination for such signs is advisable and the patient should be told to discontinue the product if they are observed. These symptoms regress quickly on withdrawing the medication. Neomycin-containing applications should be avoided for that patient thereafter.

PRECAUTIONS: As with other antibacterial preparations,

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Complete literature available on request from Professional Services Dept. PML.



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Disciplinary Actions . . . Michigan Board of Medicine

Meetings of November and December, 1979 and January, 1980.

NAME & ADDRESS	DATE & ACTION TAKEN	REASON
Preston W. Ports, MD 202 Millard Three Rivers, MI 49093 License: Unlicensed (Revoked) D.O.B.: 3-28-06	11-9-79 Intent to deny licensure upheld	Previously revoked in 10-1-76 Request for relicensure denied.
Bruce K. Clark, MD 4910 Monroe Street, Lot #40, Toledo, OH 43623 License: Unlicensed (Revoked) D.O.B.: 10-24-30	11-20-79 Intent to deny licensure upheld	Previously revoked in 8-31-77 Request for relicensure denied.
Paul A. Dosch, MD 300 McClellan Street Grayling, MI 49738 License #021980 D.O.B.: 8-14-29	11-1-79 Reprimand	Failure to use reasonable care and discrimination in the administration of drugs and failure to employ acceptable scientific methods in selection of drugs or other modalities for treatment of disease. Prescribing drugs for other than legal and legitimate therapeutic purposes. Failure to conform to minimal standards.
John J. Knox, MD Box 131, R#1 Fargo, ND 58102 License #034614 D.O.B.: 8-12-46	12-5-79 Suspension 3 months	Obtaining, possessing, or attempting to obtain or possess a controlled substance without lawful authority. Selling, prescribing, giving away or administering drugs for other than lawful diagnostic or therapeutic purposes. Conviction of a misdemeanor or felony reasonably related to and adversely affecting the licensee's ability to practice in a safe and competent manner.
George E. Stokes, MD 999 Sixth Street Traverse City, MI 49684 License #020926 D.O.B.: 5-4-22	11-1-79 Probation 3 years	Mental or physical inability reasonably related to and adversely affecting licensee's ability to practice in a safe and competent manner. Substance abuse as defined in Section 6107 of the Public Health Code.

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Evaluation of the Adjunctive Use of Trimazosin in Chronic Congestive Heart Failure

Patients with chronic congestive heart failure (stable) due to cardiomyopathy, hypertension or ischemic heart disease are eligible for this study. Patients should be in at least class II or III by NYHA functional class and may be receiving digitalis and diuretics. We are assessing whether the adjunctive use of trimazosin on a long term basis (six months) will result in subjective and objective improvement. Trimazosin is a promising new quinazoline derivative, a post-synaptic alpha adrenergic blocker which appears to have promise as a safe and effective vasodilator in chronic congestive heart failure. Patients will be hospitalized on the Clinical Research Center at University Hospital in Ann Arbor. The protocol includes use of non-invasive studies (EKG, chest x-ray, echocardiogram, rest and exercise cardiac blood pool scan) and a limited invasive study (Swan Ganz cath and brachial artery intubation). The research components of the study, including outpatient follow-up, will be borne, in part, by the Clinical Research Center of The University of Michigan and the remainder by the Pfizer Pharmaceutical Company. All patients will be returned to their personal physician after the study. Any data deemed useful in the interest of patient care will be provided to the physician through correspondence. Patients are expected to provide their own transportation to and from the hospital.

For further information, please contact: Doctors Sunil Kas, Othelio Randall, or Bertram Pitt, Cardiology Division, The University of Michigan Medical Center, 313/763-5254, 763-5255.



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Physician's family faces number of stresses

By Mildred F. Carron, Ann Arbor

Let us talk about mental and emotional stress that specifically afflicts the physician and his family.

Not all stress is bad, we have learned. It may be the push that urges one to learn a new method, pass an examination, or lose weight. This is the kind of stress we use to help ourselves.

Stressful situations

Stress for the medical family comes from two areas: external — that is, how the world feels about us; and internal — how the people within our homes act and react toward each other.

Each of us expects only the best of our mate. We fear projecting the wrong image to the world.

We are told the public considers the physician accurate, innovative, quick, personable, responsible, dependable, tuned to the feelings of others with some ESP, ready to tell a good joke and receptive to hear their jokes, and knowledgeable in every area of medical knowledge, not just their particular specialty. The public gives a God-like spirit to the physician.

When the doctor enters his or her home expecting the same God-like reverence, he or she must beware. This will create a stress situation. It is not easy to change roles, but at home the physician is husband or wife, and parent.

"When doctors practice medicine in their living rooms, they are sending out loud distress signals," states H. Waldo Bird, MD, professor of psychiatry at St. Louis University, in a recent issue of the AMA-A magazine, *Facets*. Doctors make poor

patients and it is important for a spouse to know when outside help is needed and where to get help.

Families have changed. Grandma and Grandpa probably live in Florida or Arizona and are not nearby to give a hand. Live-in housekeepers are a thing of the past. In young families it is not unusual for husband and wife to each go off to work each day, to work in their own profession. Children go off to school and come home to the baby-sitter. This could be a stress situation. It is important to work out details to everyone's satisfaction.

Spouses' dilemmas

Here's another typical situation: While he is in medical school, the physician's wife may be the wage earner. If she has not completed her education, she should consider returning to college. A physician cannot live with a poorly educated mate. Even those who volunteer their time find the work more interesting if they know how to use their heads.

"A doctor's wife," says Doctor Bird, "calls for help if she becomes disillusioned and feels her perception of strength in her husband is really his emotional control and detachment; if she loses her sense of identity, her feeling of worthwhileness and her own individuality; and if she thinks her husband likes to be with patients, and becomes sick herself to gain his attention." One thing that those who marry physicians do not foresee is loneliness.

Physicians work long hours. They make more money than the average person. They should. They are hand-selected and carefully groomed and do not start earning until they are 10 or more years out of high school.

We meet strangers who say, "Oh, a psychiatrist. That's a pretty lucrative profession, isn't it?" This is the way the public regards us. They expect a good show and often use this as a measure of ability in the practice of medicine.

But uncontrolled high income can create a stress situation. One needs a good accountant, one who is up to the minute on tax laws and can implement them to serve the physician. The physician and family must figure a budget, setting aside adequate money for taxes and insurance. Allowances for each member of the family are important considerations and should be arranged with the recipient and given with no strings. Plan early for retirement. It is upon us before we know it.

Seeking help

When we have problems, who do we go to for help? News about the doctor spreads so quickly through the medical community. Some news can tarnish a medical practice. A family must be protected and provided for first. If the doctor has a problem with alcohol or drugs or some physical ailment, the spouse knows. This is a stress situation and outside help is needed. The MSMS Committee on Impaired Physicians studies this situation. There are usually ways to help.

I have discussed a number of situations that result in stresses within the physician's family. You can probably think of others. This fishbowl life is for the hearty soul. Everyone in the doctor's family must be an individual, and be able to establish a program and goals of their own.

The doctor runs the medical practice. The spouse is the business manager for the home and the children. It is important to run one's life with love and confidence in one's mate. A home should be a sanctuary, carefully protected from unnecessary stress.

Now to answer the question, "Does a busy life add to stress?" Not if you are a good organizer. Make a list. Plan ahead. Set goals. A busy life can be very exciting. I think to be really happy, one should have just a bit more to do than one can accomplish comfortably.

Mrs. Carron is president of the MSMS Auxiliary.

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Before prescribing, see package insert for full product information.

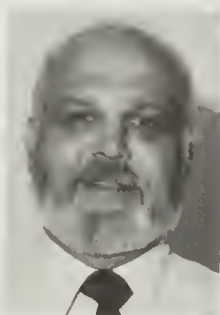
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Meet MSMS Department of Operations and Member Services



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The MSMS Department of Operations and Member Services has responsibility for the nuts and bolts activities that are so crucial to the continuity of this statewide organization for physicians. In addition, it handles all the member benefit programs, staffs several key committees, and handles arrangements for all major MSMS meetings.

Wayne E. Burmeister is the department manager, assisted by a staff of five.

Margaret (Peg) Berry is the MSMS membership secretary. She keeps track of the national and state membership status of all MSMS members, as well as those of the eight medical organizations MSMS administers through the Physician Service Group. The MSMS computer operator, "Peg" programs and prints all orders for mailing labels and mailing lists. That involves an average of 200 address changes per month. Peg also handles the registration for MSMS House of Delegates and Annual Scientific meetings.

Robert Carpenter is production room supervisor, handling all incoming and outgoing mail, printing and reproduction of all materials generated in the MSMS office. He performs the same functions for the eight other medical organizations and specialties MSMS administers.

Maynard Hoover is building supervisor, responsible for the physical upkeep and maintenance of both the MSMS headquarters building

and the new Stockwell Building. In addition, he carries out some grounds maintenance and supervises the regular landscape work.

Marcelyn Ireland is conference/exhibit coordinator and staff assistant for the MSMS Committee on CME accreditation and for the MSMS travel programs. "Marce" handles the housing, meals and meeting facilities for the more than 3,700 MSMS members and guests who participate annually in the MSMS House of Delegates, Annual Scientific, Medical Aspects of Organized Athletics and Maternal and Perinatal Health meetings. She coordinates the commercial and educational exhibits for the Annual Scientific Meeting. The committee she staffs has accredited 65 providers of continuing medical education throughout the state.

Sheryl Schooley is departmental secretary, and is responsible for CME recordkeeping services provided by MSMS computers for three Michigan

hospitals and one specialty society. Sheryl maintains files for several PSRO regions, and has responsibilities in the department's continuing membership recruitment, retention and benefit programs.

Mr. Burmeister's department works with the MSMS task forces on member benefits, group health insurance plans and member insurance plans. New members (an average of 20 per month) are welcomed to the society by this department, which mails a packet of materials to each, including the MSMS roster of members; information on insurance, car leasing and group travel plans available, and an up-to-date publication on MSMS principles and activities.

The department contacts every newly-licensed physician in the state (approximately 250 per year) inviting them to join organized medicine and describing the benefits of membership.

MSMS headquarters is readily accessible by telephone to every member.

But how many members have had the chance to visit the beautiful MSMS buildings in East Lansing and speak in person with those people behind the phone voices? Probably a majority of members have never had that chance.

Thus, *Michigan Medicine* continues with this issue to print photos of the MSMS headquarters staff along with their names and professional titles. Staff members will be grouped by departments.

This issue will feature the Department of Operations and Member Services. The Department of Economics and Finance began the series in the November issue, and Government Relations followed in December.

Other departments will be featured in future issues.



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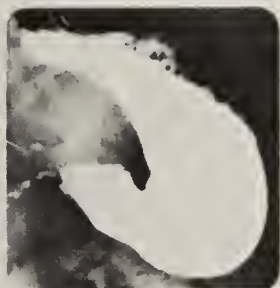
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†See Warnings, Precautions and Adverse Reactions.

See following page for prescribing information.

Reference:

King, J.C. and Starkman, N.M.: Evaluation of an antispasmodic. Double-blind evaluation to control gastrointestinal spasms occurring during radiographic examination. A preliminary report. Western Med. 5:356-358, 1964.

Merrell

SCIENTIFIC MEETING/continued

The Thursday morning course on ethical issues in medicine involved the participants in intense discussion. Leading a small group is Martin Benjamin, PhD, center, professor of philosophy and assistant coordinator for medical humanities at Michigan State University.



E. James Potchen, MD, right, director of a course on the use of the CAT Scanner, was one of several Annual Scientific Meeting speakers and leaders who were interviewed by news media.



The 75 educational exhibits were a popular feature.



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NEWS

By Katie Brewbaker, MSMS staff



Baird



Bowman



Honet



Walker

Walter M. Baird, MD, Lansing, has been appointed by Governor William G. Milliken to the Michigan Council on Physical Fitness and Health. Doctor Baird is coordinator of the heart station at Ingham Medical Hospital.

Roy T. Bergman, MD, of Escanaba, is part of the medical staff for the coming Winter Olympic Games in Lake Placid (he'll be a consultant in the polyclinic there) and the Summer Olympic Games in Moscow. In addition, Doctor Bergman is including in his busy schedule the coordination of the regional Sports Medicine Clinic in Escanaba, March 29, 1980.

Harold E. Bowman, MD, Grand Rapids, is beginning a three-year term on the Board of Governors of the 8,000 member College of American Pathologists. In addition to this new appointment, Doctor Bowman serves as president of the Doctor F. Doran Foundation, as a member of the board of directors of the American Cancer Society, and as a trustee of Aquinas College.

Accolades continue to pursue former MSMS Director **William J. Burns**. He recently was recognized by the Health Care Exhibitors Association for "both his 29 years with the Michigan State Medical Society and his 20 years with the American Pharmaceutical Association in observing the highest standards of ethical conduct, exemplary relations with the exhibiting patrons and warm personal rapport with his many friends in the exhibiting field." This represents an astonishing record of service to organized medicine but, as many MSMS members know, this is

not the complete story. Prior to joining MSMS in 1932, Mr. Burns directed the Wayne County Medical Society and the Toledo Medical Society. All told that's over a half century of vigorous medical association leadership.

The Petoskey City Council welcomes a new member to its ranks. He is **Thomas H. Gietzen, MD**, an internal medicine specialist at Burns Clinic. Commenting on his appointment, Doctor Gietzen expressed his concern that, "Government is paying too much attention to peoples' lives. I'd like to see a number of things controlled at the local level, rather than at some other governmental level."

Joseph C. Honet, MD, chairman of the Department of Rehabilitation Medicine at Sinai Hospital, Detroit, is new president of the American Academy of Physical Medicine and Rehabilitation.

William N. Hubbard, Jr., MD, former dean of the University of Michigan Medical School and now president of the Upjohn Company, returned to Ann Arbor to present the 14th annual William K. McNally Memorial Lecture at the U-M Graduate School of Business Administration. Doctor Hubbard discussed "Appropriate Science for Marketing."

It may not be "house calls" in the old sense, but three Munising physicians offer the next best thing. **Doctors Walter Olson, Eugene Hildebrand and Don Fahrback** each week pile into their special-equipped medical mobile van and visit four outlying communities providing routine med-

ical services to the people who can't make the trip to the doctors' office. These modern-day circuit riders have found their mobile van so successful they are making plans to expand their services to include the use of paramedical personnel and nurse practitioners.

Elected to the Board of Directors of the American College of Emergency Physicians is **John A. Rupke, MD**, Grand Rapids. Doctor Rupke previously has served as speaker and vice-speaker of the ACEP Council, chairman of the ACEP Long Range Planning Committee, and chairman of the Socio-economics Committee.

New presidents of Michigan special organizations are: **Robert M. Taylor, MD**, Petoskey, Michigan Society of Internal Medicine, and **Robert S. Levine, MD**, Grand Rapids, Transplantation Society of Michigan.

It was in 1946 that **Doctor Philip Wallestad** was mustered out of the U.S. Army Medical Corps as a private first class, but that didn't prevent him from re-enlisting 33 years later. Doctor Wallestad is back in uniform serving as a physician with the 440th Tactical Airlift Wing, at Mitchell Field in Milwaukee — this time as a major.

Frank B. Walker, MD, Grosse Pte. Farms, is new president of the American Society of Clinical Pathologists. AS ASCP president, Doctor Walker assumes leadership of a 25,000-member organization of professionals specializing in laboratory medicine and the study of disease, its causes, diagnosis and treatment.

Michigan Authors:

Arnold M. Weissler, MD, chief of medicine at Harper-Grace Hospitals, is editing a new major monograph entitled "Reviews of Contemporary Laboratory Methods" to be published by the American Heart Association in late 1980. The October 24 issue of *Health Care News* featured an article on **Doctor Jack Ryan's** views on government regulation of the health care industry entitled, "Regulators are Upsetting the Picture, Ryan Says."



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Robert M. Zimmerman, M.D.

MEETINGS



MSMS, MSMS/A, AMA, and medical assistants

Feb. 21-24 — 8th Annual AMA National Leadership Conference, Downtown Marriott Hotel, Chicago, contact: AMA, 535 N. Dearborn, Chicago, 60610.

March 5 — MSMS Council, MSMS headquarters, contact: Warren Tryloff, MSMS headquarters.

March 5-6 — MSMS Conference on Maternal and Perinatal Health, Hyatt Regency Dearborn, contact: Katie Brewbaker, MSMS headquarters.

March 9 — Board Meeting, State of Michigan Branch, American Association of Medical Assistants, MSMS headquarters, contact: Caroline Rich, MSMS headquarters.

April 10 — MSMS Conference on Medical Aspects of Organized Athletics, Long's, Lansing, contact: Mert Scholten, MSMS headquarters.

April 17 — AMA 33rd National Conference on Rural Health, Sheraton-Boston, contact: Barbara Chapman 312/751-6604 or Gary Schwartz 312/751-6431.

April 17-19 — Annual Convention and House of Delegates, State of Michigan Branch, American Association of Medical Assistants, Hilton Inn at Plymouth, contact: Margaret Broadwell, 16686 East Eight Mile Rd., Detroit, 48205.

April 21 — MSMS Auxiliary Legislative Day, Kellogg Center, East Lansing, contact: Caroline Rich, MSMS headquarters.

April 24-26 — AMA 76th Congress on Medical Education, Palmer House, Chicago, contact: John Fauser, MD, AMA, 535 N. Dearborn St., Chicago, IL 60610.

April 25-27 — 1980 MSMS House of Delegates, Michigan Inn, Southfield, contact: Richard Campau, MSMS headquarters.

May 5-7 — MSMS Auxiliary 54th Annual Convention, Weber Inn, Ann Arbor, contact: Caroline Rich, MSMS headquarters.

July 10-13 — MSMS Council, Holiday Inn, Marquette, contact: Warren Tryloff, MSMS headquarters.

Sept. 10 — MSMS Council, MSMS headquarters, contact: Warren Tryloff, MSMS headquarters.

Other meetings

Feb. 13 — Membership Meeting sponsored by Michigan Dermatological Society, Henry Ford Hospital, Detroit, contact: Alejandro Morales, MD, Dept. of Dermatology, Henry Ford Hospital, 2799 W. Grand Blvd., Detroit, 48202.

Feb. 13-15 — Michigan Hospital Association Smaller Hospital Conference, Sugar Loaf Mountain Lodge, contact: Michigan Hospital Association, 2213 E. Grand River Ave., Lansing, 48912.

March 5 — Membership Meeting sponsored by Michigan Dermatological Society, University of Michigan, Ann Arbor, contact: Alejandro Morales, MD, Dept. of Dermatology, Henry Ford Hospital, 2799 W. Grand Blvd., Detroit, 48202.

March 22-23, April 26-27, May 17-18 — Sexuality Training for Professionals, at Michigan League, Ann Arbor, contact: Michael Brown, 6869 Marshall Rd., Dexter, 48130, 313/426-2334.

April 7 — Wayne County Medical Society Beaumont Lecture, Henry Ford Hospital, contact: Roger Mecum, 1010 Antietam, Detroit, 48207, 313/963-1640.

May 1-2 — Annual Meeting and Resident Surgeons Day, Michigan Chapter, American College of Surgeons, at Detroit, contact: J. H. McLaughlin, MD, 604 N. Woodward, Birmingham, 48011.

May 2 — Annual Meeting, Michigan Society of Thoracic Surgeons, at Detroit, contact: Rodman E. Taber, MD, Michigan Society of Thoracic Surgeons, 30050 Hoover Rd., Warren, 48093.

May 7 — Executive Committee Meeting, Michigan Allergy Society, at Henry Ford Hospital, Detroit, contact: Benjamin Stone, MD, 1005 Abbott Rd., East Lansing, 48823.

May 21-23 — Michigan Hospital Association Medical Staff/Trustee/Administrator Forum, Boyne Mountain Lodge, contact: Michigan Hospital Association, 2213 E. Grand River Ave., Lansing, 48912.

May 29-31 — 1980 American Hospital Association National Conference on Trustees, Renaissance Center, Detroit, contact: American Hospital Association, 840 N. Lakeshore Dr., Chicago, 60611.

June 7-8 — Spring Symposium, Michigan Otolaryngological Society, at Bay Valley Inn, Bay City, contact: Dieter Wendling, MD, Macomb Ear, Nose and Throat Center, 14 Belleview, Mt. Clemens, 48043.

June 13-15 — Annual Meeting Michigan Dermatological Society, Bay Valley Inn, Bay City, contact: Alejandro Morales, MD, Dept. of Dermatology, Henry Ford Hospital, 2799 W. Grand Blvd., Detroit, 48202.

June 13-15 — Annual Meeting, Michigan Chapter, American College of Chest Physicians, at Boyne Highlands, Boyne City, contact: Susan Gibson, American Lung Association of Southeast Michigan, 28 W. Adams, Detroit, 48226, 313/961-1697.

June 26-27 — Michigan Hospital Association Annual Meeting, Grand Hotel, Mackinac Island, contact: Michigan Hospital Association, 2213 E. Grand River Ave., Lansing, 48912.

July 8-10 — Annual Scientific Meeting, Michigan Chapter American Academy of Pediatrics, Bay Valley Inn, Bay City, contact: Miles Tiernan, 32245 Hearthstone, Farmington Hills, 48018, 313/553-3646.



1980 Michigan Conference on Maternal and Perinatal Health

March 5

- ULTRASONOGRAPHY
— Charles W. Hohler, II, MD, Washington
- SENSORS
— Alistair G. S. Philip, MD, Vermont
- IMMUNOLOGY & LACTATION
— Alan E. Beer, MD, U-M
- VIRAL INFECTIONS
— John L. Sever, MD, Maryland
- BACTERIAL INFECTIONS
— Rudolph P. Galask, MD, Iowa

March 6

- APPLIED ANESTHESIOLOGY/HIGH RISK PREGNANCY
— Gertie F. Marx, MD, New York
- APPLIED ANESTHESIOLOGY/LOW RISK PREGNANCY
— Edward G. Bartholomew, MD, Detroit
- TERATOLOGY
— John L. Sever, MD, Maryland
- ADOLESCENT PREGNANCY
— Jack M. Stack, MD, Alma
— Marilyn Poland, PhD, WSU
— Darlene Hinkle, MDPH

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CATEGORY I COURSES

Michigan Medicine each month carries a list of opportunities in Michigan for doctors of medicine to obtain Category I credit toward meeting the requirements of Michigan law. Sponsors of Category I programs and courses in Michigan are invited to submit information for the monthly calendar.

Each listing below, of programs that carry at least 3 hours of Category I credit, indicates a contact person, so the physician can obtain details. Physicians with questions about accredited programs may phone MSMS Headquarters, 517/337-1351.

Date: Feb. 9-16, 1980, **Infectious Diseases Today.** **Location:** Aboard tss Festivale in the Caribbean. **Sponsor:** Wayne State University School of Medicine, Div. of CME. **For:** All interested physicians. **Contact:** Wayne State University School of Medicine, Division of Continuing Medical Education, 1206 Scott Hall, Detroit, MI 48201 (313) 577-1180. **Approved for:** 36 hours of Category I Credit.

Date: Feb. 13, 20, 27 and March 5, 12 & 19, 1980, **Child Development.** **Location:** Auditorium, Mount Carmel Mercy Hospital, Detroit. **Sponsor:** Mt. Carmel Mercy Hospital, Sinai Hospital of Detroit and the Michigan Psychiatric Society. **For:** Psychiatrists. **Cost:** \$25. **Contact:** Daniel Schwartz, Dept. of Psychiatry, Sinai Hospital of Detroit, 6767 West Outer Dr., 48235. **Approved for:** 9 hours of Category I Credit.

Date: Feb. 18-22, 1980, **Emergency Medicine.** **Location:** Towsley Center, Ann Arbor. **Sponsor:** U-M Office of Continuing Education. **For:** Emergency physicians, Family physicians, Internists, EMT's. **Cost:** \$275. **Contact:** Towsley Center for CME, 313/764-2287. **Approved for:** 36½ hours of Category I Credit.

Date: Feb. 21, **Obstetrics and Gynecology Weekly Seminar.** **Location:** Henry Ford Hospital, Detroit. **Sponsor:** Henry Ford Hospital. **For:** All interested physicians. **Cost:** No charge. **Contact:** B.H. Druckker, MD, (313) 876-2464. **Approved for:** 3 hours of Category I Credit.

Date: Feb. 21, **"Antenatal Assessment of Fetal Well-Being."** **Location:** Edward W. Sparrow Hospital, Lansing. **Sponsor:** Michigan Society of Obstetricians and Gynecologists and Michigan Section, American College of Obstetricians and Gynecologists. **For:** Obstetricians and Gynecologists. **Cost:** \$3 luncheon charge. **Contact:** Richard W. Pomeroy, MD, (517) 487-2511. **Approved for:** 4 hours of Category I Credit.

Date: Feb. 22-24, 1980, **Mid-Winter Meeting.** **Location:** Hospitality Inn, Lansing. **Sponsor:** Michigan Academy of Family Physicians. **For:** Family physicians. **Cost:** \$85. **Contact:** Michigan Academy of Family Physicians, 416 North Homer, Suite #107, Lansing, MI 48912. **Approved for:** 14 hours of Category I Credit.

Date: Feb. 23, **Orthopedic Conference.** **Location:** Henry Ford Hospital, Detroit. **Sponsor:** Henry Ford Hospital. **For:** All interested physicians. **Cost:** No charge. **Contact:** E. R. Guise, MD (313) 876-2188. **Approved for:** 3 hours of Category I Credit.

Date: Feb. 25, 26, 28 and March 1, **Advanced Cardiac Life Support.** **Location:** Education and Research Center, Henry Ford Hospital. **Sponsor:** Henry Ford Hospital. **For:** All interested physicians. **Cost:** \$175. **Contact:** Medical Education, Henry Ford Hospital, 2799 W. Grand Blvd., Detroit, 48202 (313) 876-1464. **Approved for:** 20 hours of Category I Credit.

Date: Feb. 26-27, **Aging: Psychiatric Problems and Their Management.** **Location:** Towsley Center, Ann Arbor. **Sponsor:** U-M Office of Continuing Medical Education. **For:** All interested physicians. **Cost:** \$120. **Contact:** Towsley Center

for CME, 313/764-2287. **Approved for:** 13¾ hours of Category I Credit.

Date: March 10-14, **Diagnostic Radiology: Practical Approaches to Common Problems.** **Location:** Northstar, Lake Tahoe. **Sponsor:** Oakland Hospital. **Co-Sponsor:** American College of Radiology. **For:** All interested physicians. **Cost:** \$300. **Contact:** Alan T. Hennessey, MD, or Joyce Esper, 313-336-3000, ext. 236. **Approved for:** 30 hours of Category I Credit.

Date: March 11-12, **Childhood Cancer, Re-establishing Normalcy.** **Location:** Towsley Center, Ann Arbor. **Sponsor:** U-M Office of Continuing Education. **For:** All interested physicians and health professionals. **Cost:** \$65. **Contact:** Towsley Center for CME, 313/764-2287. **Approved for:** 13 hours of Category I Credit.

Date: March 15, **Genetic Disease in Clinical Practice.** **Location:** Education and Research Center, Henry Ford Hospital. **Sponsor:** Henry Ford Hospital. **For:** All interested physicians. **Cost:** \$70. **Contact:** Medical Education, Henry Ford Hospital, 2799 W. Grand Blvd., Detroit, (313) 876-1464. **Approved for:** 7 hours of Category I Credit.

Date: March 19-21, 1980, **Advances in Pediatrics.** **Location:** Towsley Center, Ann Arbor. **Sponsor:** U-M Office of Continuing Medical Education. **For:** All interested physicians. **Cost:** \$190. **Contact:** Towsley Center for CME, 313/764-2287. **Approved for:** 21 hours of Category I Credit.

Date: March 19, 1980, **Infectious Diseases in Obstetrics and Gynecology.** **Location:** Saint John Hospital. **Sponsor:** CME Committee of Saint John Hospital. **For:** All interested physicians. **Cost:** \$90. **Contact:** Ms. Linda Radu, Secretary, Continuing Medical Education, Department of Health Education, Saint John Hospital, 22101 Moross Road, Detroit 48236 (313/343-4000). **Approved for:** 8 hours of Category I Credit.

Date: March 20-21, **Advances in Pediatrics: Topics in Neurology and Endocrinology.** **Location:** Towsley Center, Ann Arbor. **Sponsor:** U-M Office of Continuing Medical Education. **For:** All interested physicians. **Cost:** \$120. **Contact:** Towsley Center for CME, 313/764-2287. **Approved for:** 13¾ hours of Category I Credit.

Date: March 22, **Radiation Therapy in Everyday Clinical Practice.** **Location:** Education and Research Center, Henry Ford Hospital. **Sponsor:** Henry Ford Hospital. **For:** All interested physicians. **Cost:** \$55. **Contact:** Medical Education, Henry Ford Hospital, 2799 W. Grand Blvd., Detroit, 48202 (313) 876-1464. **Approved for:** 5½ hours of Category I Credit.

Date: March 23, **22nd Annual Spring Clinic.** **Location:** Valley View Restaurant, Shepherd. **Sponsor:** Central Michigan Community Hospital. **Co-Sponsor:** Gratiot Community Hospital. **For:** All interested physicians. **Contact:** Frank D. Johnson, MD, Central Michigan Community Hospital, 1221 South Drive, Mt. Pleasant, 48858. **Approved for:** 8 hours of Category I Credit.

Date: March 26, **Placental Pathology — Clinical Applications.** **Location:** Michigan Inn, Southfield. **Sponsor:** Michigan Society of Obstetricians and Gynecologists and Michigan Section, American College of Obstetricians and Gynecologists. **For:** Obstetricians and Gynecologists. **Contact:** Don R. Krohn, MD, Dept. of OB/GYN, Providence Hospital, Southfield, (313) 424-3000. **Approved for:** 7 hours of Category I Credit.

Date: March 26-28, 1980, **Urology Conference.** **Location:** Towsley Center, Ann Arbor. **Sponsor:** U-M Office of Continuing Medical Education. **For:** All interested physicians. **Cost:** \$175. **Contact:** Towsley Center for CME, 313/764-2287. **Approved for:** 21 hours of Category I Credit.

Date: March 27-April 2, 1980, **MAFP and SCAFP "Ails of Summer" Meeting.** **Location:** Kiawah Island, Charleston, SC. **Sponsor:** Michigan Academy of Family Physicians and South Carolina Academy of Family Physicians. **For:** Family physicians. **Cost:** \$100. **Contact:** Michigan Academy of Family Physicians, 416 North Homer, Suite #107, Lansing, MI 48912. **Approved for:** 25 hours of Category I Credit.

Date: March 29, 1980, **Gastroenterology for the Family Physician.** **Location:** Towsley Center, Ann Arbor. **Sponsor:** U-M Office of Continuing Medical Education. **For:** All interested physicians. **Contact:** Towsley Center for CME, 313/764-2287. **Approved for:** 7 hours of Category I Credit.

Date: April 10-11, **General Surgery.** **Location:** Towsley Center, Ann Arbor. **Sponsor:** U-M Office of Continuing Medical Education. **For:** All interested physicians. **Cost:** \$160. **Contact:** Towsley Center for CME, 313/764-2287. **Approved for:** 14 hours of Category I Credit.

Date: April 10-11, **Symposium on Gastrointestinal Hemorrhage.** **Location:** Towsley Center, Ann Arbor. **Sponsor:** U-M Office of Continuing Medical Education. **For:** General Surgeons, gastroenterologists, internists, family physicians and radiologists. **Cost:** \$190. **Contact:** Towsley Center, Office of CME, 313/764-2287. **Approved for:** 16 hours of Category I Credit.

Date: April 14-18, **Family Practice Review.** **Location:** Towsley Center, Ann Arbor. **Sponsor:** U-M Office of Continuing Medical Education. **For:** All interested physicians. **Cost:** \$275. **Contact:** Towsley Center for CME, 313/764-2287. **Approved for:** 33 hours of Category I Credit.

Date: April 23-25, **Hematology Review.** **Location:** Towsley Center, Ann Arbor. **Sponsor:** U-M Office of Continuing Medical Education. **For:** Hematologists, Medical Technologists. **Cost:** \$190. **Contact:** Towsley Center for CME, 313/764-2287. **Approved for:** 24 hours of Category I Credit.

Date: April 28-30, **Ob-Gyn Conference.** **Location:** Towsley Center, Ann Arbor. **Sponsor:** U-M Office of Continuing Medical Education. **For:** All interested physicians. **Cost:** \$175. **Contact:**

continued on page 98

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CATEGORY I COURSES/continued

Towsley Center for CME, 313/764-2287. **Approved for:** 21 hours of Category I Credit.

Date: April 30, **Hypertension: Evaluation and Treatment.** **Location:** Towsley Center, Ann Arbor. **Sponsor:** U-M Office of Continuing Medical Education. **For:** All interested physicians. **Cost:** \$65. **Contact:** Towsley Center for CME, 313/764-2287. **Approved for:** 7 hours of Category I Credit.

Date: May 2-3, 1980, **Nuclear Radiology Workshop.** **Location:** Towsley Center, Ann Arbor. **Sponsor:** U-M Office of Continuing Medical Education. **For:** All interested physicians. **Cost:** \$150. **Contact:** Floyd C. Pennington, Director, Office of Continuing Medical Education, Towsley Center, University of Michigan Medical School, Ann Arbor 48109. **Approved for:** 16 hours of Category I Credit.

Date: May 8-9, **Ophthalmology Conference.** **Location:** Towsley Center, University of Michigan. **Sponsor:** U-M Office of Continuing Medical Education. **For:** Ophthalmologists. **Cost:** \$160. **Contact:** Towsley Center for CME, 313/764-2287. **Approved for:** 16 hours of Category I Credit.

Date: May 9, **Oto Clinical Conference.** **Location:** Towsley Center, University of Michigan. **Sponsor:** U-M Office of Continuing Medical Education. **For:** All interested physicians. **Cost:** \$25. **Contact:** Towsley Center for CME, 313/764-2287. **Approved for:** 5½ hours of Category I Credit.

Date: May 10, **Pulmonary Pathology and Transbronchial Biopsy.** **Location:** Borgess Hospital, Kalamazoo. **Sponsor:** Michigan Society of Pathologists. **For:** Pathologists. **Contact:** T. A. Reyman, MD, Department of Pathology, Mt.

Carmel Mercy Hospital, 6071 W. Outer Dr., Detroit 48202. **Approved for:** 3 hours of Category I Credit.

Date: May 12-16, **Head and Neck Oncology.** **Location:** Towsley Center, University of Michigan. **Sponsor:** U-M Office of Continuing Medical Education. **For:** All interested physicians. **Cost:** \$500. **Contact:** Towsley Center for CME, 313/764-2287. **Approved for:** 42½ hours of Category I Credit.

Date: May 19-23, **Advances in Internal Medicine.** **Location:** Towsley Center, U-M. **Sponsor:** U-M Office of Continuing Medical Education. **Cost:** \$290. **Contact:** Towsley Center for CME, 313/764-2287. **Approved for:** 35 hours of Category I Credit.

Date: May 21, 1980, **Medical Therapy in Family Practice.** **Location:** Saint John Hospital. **Sponsor:** CME Committee of Saint John Hospital. **For:** All interested physicians. **Cost:** \$90. **Contact:** Ms. Linda Radu, Secretary, Continuing Medical Education, Department of Health Education, Saint John Hospital, 22101 Moross Road, Detroit 48236 (313/343-4000). **Approved for:** 8 hours of Category I Credit.

Date: July 25-27, 1980, **EKG Interpretation and Arrhythmia Management.** **Location:** Grand Hotel, Mackinac Island. **Sponsor:** International Medical Education Corporation. **For:** All interested physicians. **Cost:** \$215.00. **Contact:** International Medical Education Corporation, Division of Postgraduate Education, Dept. 12, 64 Inverness Drive East, Englewood, CO 80112 (800) 525-8646 Toll Free or (313) 773-1144. **Approved for:** 15 hours of Category I Credit.

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*Mr. Pollack has appeared on TV's "Wall Street Week" and has been the subject of articles in Money Magazine, Forbes Magazine, Finance Magazine, and is regularly quoted in The Wall Street Journal. He is the Chairman and President of Shearson Management Inc. and was educated at Yale University and the Harvard Business School.



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DEATHS

Bernard Bernbaum, MD Troy

Bernard Bernbaum, MD, Troy, died Nov. 2. He was 83. Doctor Bernbaum earned his MD at Wayne State University School of Medicine. He had served on the staffs of Children's, Harper, Mt. Carmel, Herman Kieffer and Providence hospitals, and was an associate professor of medicine at Wayne State.

Edith Hall-Kent, MD Lansing

Edith Hall-Kent, MD, Lansing, died November 15. She was 81. Doctor Hall-Kent received her MD at the University of Manitoba, Winnipeg, Canada. She was a staff member at Ingham Medical, St. Lawrence and Edward W. Sparrow Hospitals. Doctor Hall-Kent was a member of the Michigan Pediatric Society of Detroit, a member of the 50 Years Club of American Medicine and had been honored for 40 years of service by the St. Lawrence Hospital. She was listed in *Who's Who of American Women*.

Gordon H. Heald, MD Okemos

Gordon H. Heald, MD, Okemos, died Oct. 23 at the age of 64. He received his MD from CME Medical School in Los Angeles. Doctor Heald conducted a private practice in East Lansing for 25 years and for the past seven years had been associated with the State of Michigan Disability Determination Program, Department of Education.

Charles W. Husband, MD Detroit

Charles W. Husband, MD, Detroit, died Nov. 3. He was 91. He earned his MD in 1912 from the Detroit College of Medicine. Doctor Husband joined the surgical staff of Mt. Carmel Mercy Hospital when it opened in 1938. He performed the first surgical procedure in the then new hospital. Doctor Husband was also a senior surgeon for 25 years at Providence Hospital in Southfield.

Povilas Sepetys, MD Southfield

Povilas Sepetys, MD, Southfield, died Nov. 14 at the age of 62. Doctor Sepetys was graduated from medical school in Munich, Germany and came to the United States in 1954. During his career, Doctor Sepetys was on the staffs of Providence and Herman Kieffer Hospitals.

Fred G. Swartz, MD Traverse City

Fred G. Swartz, MD, Traverse City, died Dec. 5 at the age of 92. Doctor Swartz was the first director of the Grand Traverse Medical Care Facility and served in that capacity from 1959 to 1965. He was a former mayor of Traverse City and a past president of the Tri-County Medical Society. Doctor Swartz received his MD from the University of Colorado Medical School.

R. Wallace Teed, MD Ann Arbor

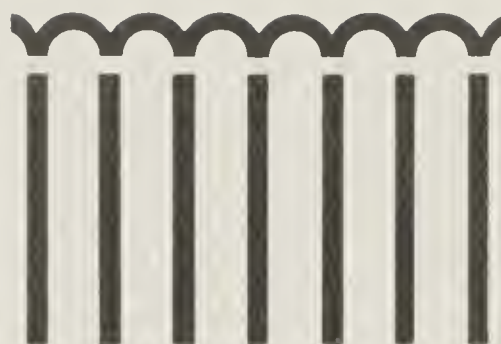
R. Wallace Teed, MD, Ann Arbor, died Oct. 25. He was 78. He received his MD from the University of Michigan in 1927. Doctor Teed was a member of the Detroit Society of Otolaryngology. In addition to being a past president of the Washtenaw County Medical Society, Doctor Teed had served in the Michigan State Medical Society House of Delegates.

Vincent J. Turcotte, Sr., MD Ann Arbor

Vincent J. Turcotte, Sr., MD, Ann Arbor, died Nov. 3 at the age of 82. He was chief of staff and chairman of the obstetrics and gynecology department at St. Mary Hospital. He was also a founding member of the College of Obstetrics and Gynecology. Doctor Turcotte received his MD from the University of Michigan.

Howard S. Willson, MD East Lansing

Howard S. Willson, MD, East Lan-



sing, died Dec. 6 at the age of 81. Doctor Willson earned his MD from Hahnemann Medical College of Philadelphia. During the 50 years he practiced medicine in Lansing he was affiliated with Edward Sparrow and St. Lawrence hospitals. Doctor Willson also served as past treasurer of the Ingham County Medical Society.

Warren A. Wise, MD St. Joseph

Warren A. Wise, MD, St. Joseph, died Dec. 2. He was 47. Doctor Wise earned his MD from the University of Chicago in 1959. He was a fellow in the American College of Surgeons and had practiced in St. Joseph since 1965. Doctor Wise was affiliated with Mercy Hospital in Benton Harbor and Memorial Hospital in St. Joseph.

NEW MEMBERS



Members of the Michigan State Medical Society join in welcoming the following new members into a progressive state medical organization. MSMS is dedicated to promoting the science and art of medicine, the protection of the public health, and the betterment of the medical profession. Each new member is encouraged to join with other MSMS members at both the local and state levels in achieving these goals.

Laurens V. Ackerman, MD	DR	C. Peter Fischer, MD	U	Sailen K. Mukerjee, MD	I
625 Spring Valley Rd. Ann Arbor, 48105		3075 Clark Rd. Ypsilanti, 48197		44067 Palisades Ct. Canton, 48187	
Steven A. Aiken, MD	FP	William J. Foley, III, MD	IM	George P. Olson, MD	GI
25901 E. Jefferson St. Clair Shores, 48080		515 Lakeside Dr., S.E. Grand Rapids, 49506		2649 Crooks Rd. Troy, 48084	
Alan E. Beer, MD	OBG	Denise G. K. Gray, MD	R	Jean O. Partamian, MD	IM/DIA
L2120 Women's Hosp. U of M Ann Arbor, 48109		1412 E. 11 Mile Rd. Royal Oak, 48067		Henry Ford Hosp. Detroit, 48202	
Richard A. Berg, MD	CDS/GS	David D. Hamm, MD	IM/RHU	Daniel J. Reddy, MD	GS/CDS
677 Neff Grosse Pte., 48230		1900 Wealthy St., S.E. Grand Rapids, 49506		Henry Ford Hosp. Detroit, 48202	
Jayant Dinkar Bhat, MD	U	John M. Hutson, MD	OBG	Dietrich W. Roloff, MD	PE
952 Fisher Bldg. Detroit, 48202		4201 St. Antoine Detroit, 48201		L3018 Women's Hosp. U of M Ann Arbor, 48109	
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456 Cherry St., S.E. Grand Rapids, 49503		2800 Georgetown Dr. Midland, 48640		2350 Washtenaw Ann Arbor, 48104	
Candace R. Caveny, DO	PM	Robert F. Johnson, Jr., MD	IM	Ila A. Shah-Reddy, MD	IM/HEM
15013 Mapleridge Detroit, 48205		515 Lakeside Dr., S.E. Grand Rapids, 49506		4707 St. Antoine Detroit, 48201	
Kathleen E. Chase, MD	AN	Mansour Kiumehr, MD	OBG	Bradley J. Scheel, MD	IM
13400 Beckwith Dr., N.E. Lowell, 49331		4944 Cimarron Bloomfield Hills, 48013		Henry Ford Hosp. Detroit, 48202	
Jong Kook Choe, MD	P	Paul A. Lafia, MD	IM	Ronald S. Schmier, MD	AN
17426 Edgewood Livonia, 48152		468 Cadieux Grosse Pte., 48230		1974 Villa Birmingham, 48008	
Susan G. Coleman, MD	IM	H. George Levy, MD	OTO	William J. Somerville, MD	GP/EM
6033 Middlebelt Garden City, 48135		Henry Ford Hosp. Detroit, 48202		310 River St. Manistee, 49660	
A. J. Darin de Lorenzo, MD	P	Peter B. Lundeen, MD	FP	Timothy J. Tobolic, MD	FP
Henry Ford Hosp. Detroit, 48202		1275 Colrain, S.W. Wyoming, 49509		1502 Fisk, S.E. Grand Rapids, 49506	
Mark S. Fettman, MD	P	Jerry W. Luoma, MD	FP	Nguyen Huu Tri, MD	FP
2200 Fuller Rd. #109B Ann Arbor, 48105		414 Hecla St. Laurium, 49913		1724 Aberdeen, N.E. Grand Rapids, 49505	
		Anwar Mahmood, MD	IM	Kumarapuram Venkatachalam, MD	IM/NEP
		36079 Congress Rd. Farmington, 48018		Henry Ford Hosp. Detroit, 48202	
		Joseph W. McGoey, MD	D	Thomas A. Weimert, MD	OTO
		2799 W. Grand Blvd. Detroit, 48202		2050 PO Box 994 Ann Arbor, 48106	
		Gary M. Mikel, MD	V	Shirani Wijayasuriya, MD	IM/ON
		416 Tamarack St. Laurium, 49913		9880 E. Michigan Ave. Galesburg, 49053	
		Anilkumar M. Mody, MD	GS		
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Student Oriented Health Service serving 7,500 technical student population seeks primary care physician. Outpatient clinic, shared call. Liberal fringes, competitive wage. Contact: J. L. Anderson, MD, Director, MTU Health Service, Houghton, MI 49931, or call 906-487-2435. Michigan Technological University is an Equal Opportunity Educational Institution/Equal Opportunity Employer.

Experienced Physician for University Health Center. Malpractice coverage and excellent fringe benefits. Beautiful clinic on campus in well located, civic minded city. Salary negotiable. Position open approximately September, 1980. Contact: Donald T. McNally, Director, University Health Center, Western Michigan University, Kalamazoo, MI 49008. Call collect: (616) 383-6003.

General/Family Practice Physician. For group of five clinics in Detroit innercity and suburbs. Plenty of professional freedom. Hours 10 a.m. to 6 p.m. with hospital optional. Malpractice, medical, dental, life and disability insurance paid, also auto allowance. Trail Clinics, 16840 E. Warren, Detroit. (313) 882-7060 Cindy Thompson.

Wanted: Industrial Physician (Full or Part Time), Large Industrial Corporation. Salary competitive, malpractice insurance, excellent employee benefits including: life insurance, hospitalization, major medical insurance, accident-sickness insurance-long term disability, dental insurance, liberal vacation and retirement program-stock investment plan, CME time. Send curriculum vitae references to P.O. Box #29848, Detroit, MI 48229.

Marquette, Michigan. Urologist needed immediately or in the near future to replace urologist in a two man practice. Marquette is a university community on the unspoiled south shore of Lake Superior. Admitting privileges at Marquette General Hospital offering regional medical care for people in the central area of the Upper Peninsula. 18 bed urologic unit, fully equipped hospital with advanced lab facilities; ultrasound, CT scanner; excellent radiologic service. Hospital has a young and excellently trained nephrologist; active cardiovascular surgery service. Current staff of 79 solo and a small group of private practice practitioners. 87% board certified, average age of active staff is 42 years. Please contact: John D. Wojcik, MD, Marquette General Hospital, 420 West Magnetic Street, Marquette, Michigan 49855. Phone: 906-228-9440.

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Subspecialty Internists — Excellent Opportunity. Pleasant Atmosphere.

McLaren General Hospital, Flint, Michigan, is currently seeking internists in all subspecialties for teaching faculty positions in Internal Medicine associated with hospital-based private practice. Opportunity provides quarter-time paid teaching salary, excellent private practice setting. Physicians must be ABIM certified and subspecialty certified/eligible. McLaren General Hospital is a 469 bed university-affiliated, excellent acute care hospital with General Surgery, Internal Medicine, Orthopaedic Surgery, Ob-Gyn, and Psychiatry training programs and undergraduate recreational and cultural opportunities. Address inquiries and C.V. to: Michael Giacalone, Jr., MD, Director of Medical Education, McLaren General Hospital, 401 S. Ballenger Hwy., Flint, Michigan 48502. (313) 762-2321.

Medical Director Wanted for Jackson Med Center, Inc. a non-profit clinic. Position includes directing capable medical support staff, monitoring and providing patient care and planning for future expansion of present and future services provided. Ideal opportunity for aggressive physician interested in operating a "no risk" general practice. Internists and/or Family Practitioner preferable. Excellent salary (presently up to \$50,000) and fringe benefits. No investment required. Max. 40 hr. work week. Resumes to: Jackson Med Center, Inc., 612 First Street, Jackson, Michigan 49201. Attention: E. Willoughby, MD.

Emergency Medicine Positions: available with Emergency Physician Group throughout Michigan, PA, NY, NJ, and Southeastern U.S. including all suburban, rural and metropolitan areas. Fee-for-services with minimum guarantee provided. Malpractice paid. Practice credits toward board certification. Please send resume to: NEEMA Emergency Medical, Ste. 400, 399 Market St., Philadelphia, PA 19106. In Pennsylvania, call 215-925-3511, those outside Pennsylvania call 1-800-523-0776.

For Sale: 3 year old family practice — Southwest Michigan — efficient operation, computer billing — grossed 140K last year — Ob optional — night coverage available for solo — ideal for compatible two-man group — owner leaving July for residency. Call collect (616) 673-5085.

Am Seeking An Associate In Family Practice. Will turn over practice to you in four to five years or less. Location in Western Michigan. For details contact MSMS, 120 W. Saginaw, Box 15, East Lansing, MI 48823.

Positions wanted

Graduating Family Practice Resident available in September 1980, seeks opportunity in group family practice or as faculty in family practice residency program in Wayne, Oakland or Macomb County. Please send reply to: Practice Opportunity, 29180 Sharidale Rd., Southfield, MI 48034.

Miscellaneous

Medical Space For Lease — 2200-4400 square feet available in Ypsilanti on Ellsworth Rd. at the corner of Hewitt. Just off the I-94 Michigan Avenue exit in busy Roundtree Village Shopping Center. Well populated area, ample parking, reasonable rent. Contact Sheldon W. Gordon in Birmingham, MI 1-313-647-7171.

Land Contract Terms Available on this beautiful Executive home, ten miles to Michigan State University. 10 acres, private and partially wooded. 4 bedrooms, 3½ baths, built in microwave and self cleaning ovens. Jenn Air Grill, intercom, mud and laundry room. Family room with natural stone fireplace and Heat-O-Later, energy efficient wood-oil furnace, basement, 2½ car garage, central vacuum, water softener, central air, humidifier, electronic air filter, T.V. antenna with rotor in attic. Phone: State Wide Real Estate of Okemos, 349-5700 or Audrey J. Jackovac, 655-3848.

Two Prime Weeks in Snowmass, Colorado for sale on Shared Time. Weeks #35 and #36 (swing weeks), for the next 19 years. You can trade this week with other weeks in the year in Snowmass or hundreds of places around the U.S. and the world. Only \$3,200.00 per week or best offer. Call (313) 653-6510.

St. Thomas, U.S.V.I. — Condominium apartment. Ocean front. Sleeps 4-6. Free tennis, three pools, duty free shopping. List of local medical meetings available. 313/543-2970 or 542-7600.

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Livonia — 7 Mile and Merriman medical building, 1350 Square Feet. Customized Suites. Immediate Occupancy. 478-2121.

Medical And Dental Office under construction — 1000 sq. ft. suite available — 4717 Sixteen Mile Road, 2 blocks east of Ryan, Sterling Heights. Call B. Monast at 313/542-7100.



PRESIDENT'S PAGE

If your mind is made up, don't let me confuse you with the facts

By Ernest P. Griffin, Jr., MD, MSMS President

This essay is based on additional information gleaned from a preliminary study of the cases in the files of the Michigan Physicians Mutual Liability Company.

The MPMLC Risk Management Committee continues its work and in the future will issue definitive reports to you. However, while we wait for the results of the in-depth studies, there are situations you should know about now.

"Doctor Motormouth" is still with us. The species is highly variable and at times defies recognition. Some of his/her characteristics are difficult to delineate and I suppose some are obvious.

However, on the chance that you may be a member of this ignominious species, let us look at some of the distinguishing habits.

The most outstanding example is the individual that knows he/she never made a mistake or had an unfortunate result in all of his/her years of medical practice. This opinion is not changed even after "Motormouth's" insurance company has paid the jury awards to the injured patients. All other physicians are inferior and "Motormouth" will be the first to tell you. He/she is rare and probably unreachable.

Fortunately, the other members of the species are categorized by their unintentional acts of omission or commission. It is within our power to aid our profession in this arena.

The well-meaning, ethical, subsequent-treating physician sees the patient for the first time. He/she makes no effort to obtain the previous record or consult the original treating physician and accepts the patient's uninformed opinion as fact.

Now the stage is set.

During the history and physical examination, the "I-wonder-whys," the "ums," the "ohs," the raising of the eyebrows, the "how-did-this-happens" and the "I-probably-would-haves" are enough to generate extreme skepticism on the part of the patient. It requires very little imagination for the patient to assume that the original treating physician made a grave error. This can be the focal point from which an unwarranted lawsuit can arise.

Then there is the physician who arrives on the scene just after a medical team has lost a heroic battle to save a patient's life. This physician makes no attempt to ascertain the facts but begins to issue criticisms in a loud and forceful manner. Naturally, the relatives will be seeing the team members at the courthouse.

And there is the medical staff of the hospital center that receives referred difficult cases. The resident presents the case with the opening line, "Well, chief, here is another bad one from Elsewhere General Hospital." Regardless of the facts, this attitude can lead to another visit

to the courthouse by the referring physician.

The facts of the matter are that many of our insurance dollars are spent on long discovery proceedings that, when the realities are ascertained, result in no action.

There are times when the first reaction is a lawsuit and then it is necessary to prove the treatment under the actual circumstances was perfectly proper and adequate. Either one of these scenarios can be very expensive.

If your mind is made up that physicians do not do these things, then I hope I have confused you with the facts.

Before prescribing, please consult complete product information, a summary of which follows:

The effectiveness of Valium (diazepam) in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.

Contraindications: Tablets in children under 6 months of age, known hypersensitivity; acute narrow angle glaucoma may be used in patients with open angle glaucoma who are receiving appropriate therapy

Warnings: As with most CNS-acting drugs, caution against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Withdrawal symptoms (similar to those with barbiturates, alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal/muscle cramps, vomiting, sweating). Keep addiction-prone individuals (drug addicts or alcoholics) under careful surveillance because of predisposition to habituation/dependence

Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations, as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

ORAL: Advise patients against simultaneous ingestion of alcohol and other CNS depressants.

Not of value in treatment of psychotic patients; should not be employed in lieu of appropriate treatment. When using oral form adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increase in dosage of standard anticonvulsant medication; abrupt withdrawal in such cases may be associated with temporary increase in frequency and/or severity of seizures

INJECTABLE: To reduce the possibility of venous thrombosis, phlebitis, local irritation, swelling, and, rarely, vascular impairment when used I.V.: inject slowly, taking at least one minute for each 5 mg (1 ml) given; do not use small veins, i.e., dorsum of hand or wrist, use extreme care to avoid intra-arterial administration or extravasation. Do not mix or dilute Valium with other solutions or drugs in syringe or infusion flask. If it is not feasible to administer Valium directly I.V., it may be injected slowly through the infusion tubing as close as possible to the vein insertion.

Administer with extreme care to elderly, very ill, those with limited pulmonary reserve because of possibility of apnea and/or cardiac arrest, concomitant use of barbiturates, alcohol or other CNS depressants increases depression with increased risk of apnea, have resuscitative facilities available. When used with narcotic analgesic eliminate or reduce narcotic dosage at least 1/3, administer in small increments. Should not be administered to patients in shock, coma, acute alcoholic intoxication with depression of vital signs

Has precipitated tonic status epilepticus in patients treated for petit mal status or petit mal variant status.

Withdrawal symptoms (similar to those with barbiturates, alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal/muscle cramps, vomiting, sweating). Keep addiction-prone individuals under careful surveillance because of predisposition to habituation/dependence. Not recommended for OB use.

Efficacy/safety not established in neonates (age 30 days or less); prolonged CNS depression observed. In children, give slowly (up to 0.25 mg/kg over 3 minutes) to avoid apnea or prolonged somnolence, can be repeated after 15 to 30 minutes. If no relief after third administration, appropriate adjunctive therapy is recommended.

Precautions: If combined with other psychotropics or anticonvulsants, carefully consider individual pharmacologic effects—particularly with known compounds which may potentiate action of Valium (diazepam), i.e., phenothiazines, narcotics, barbiturates, MAO inhibitors and antidepressants. Protective measures indicated in highly anxious patients with accompanying depression who may have suicidal tendencies. Observe usual precautions in impaired hepatic function, avoid accumulation in patients with compromised kidney function. Limit oral dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation (initially 2 to 2½ mg once or twice daily, increasing gradually as needed or tolerated).

INJECTABLE: Although promptly controlled seizures may return readminister if necessary, not recommended for long-term maintenance therapy. Laryngospasm increased cough reflex are possible during peroral endoscopic procedures, use topical anesthetic, have necessary countermeasures available. Hypotension or muscular weakness possible, particularly when used with narcotics, barbiturates or alcohol. Use lower doses (2 to 5 mg) for elderly/debilitated.

Adverse Reactions: Side effects most commonly reported were drowsiness, fatigue, ataxia. Infrequently encountered were confusion, constipation, depression, diplopia, dysarthria, headache, hypotension, incontinence, jaundice, changes in libido, nausea, changes in salivation, skin rash, slurred speech, tremor, urinary retention, vertigo, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances and stimulation have been reported, should these occur, discontinue drug.

Because of isolated reports of neutropenia and jaundice, periodic blood counts, liver function tests advisable during long-term therapy. Minor changes in EEG patterns, usually low-voltage fast activity have been observed in patients during and after Valium (diazepam) therapy and are of no known significance.

INJECTABLE: Venous thrombosis/phlebitis at injection site, hypoactivity, syncope, bradycardia, cardiovascular collapse, nystagmus, urticaria, hiccups, neutropenia.

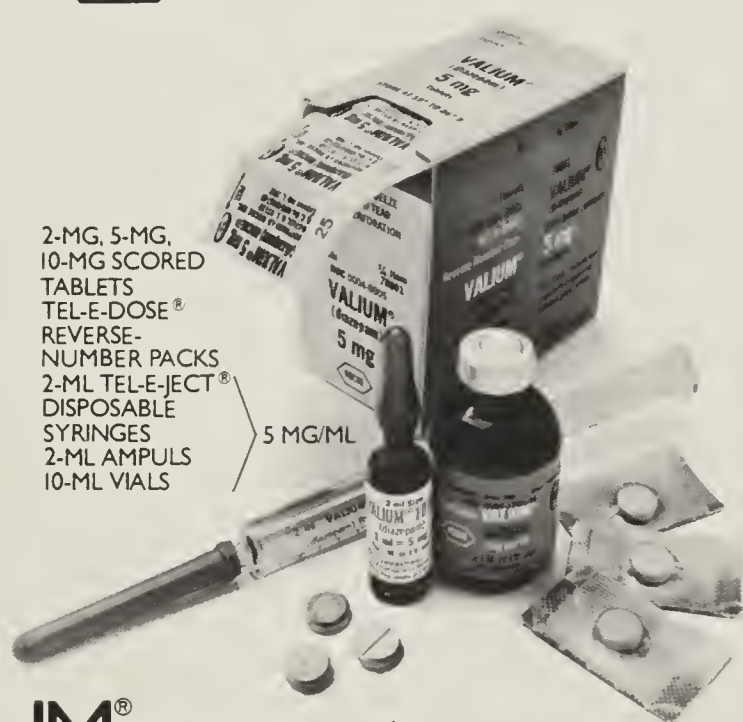
In peroral endoscopic procedures, coughing, depressed respiration, dyspnea, hyperventilation, laryngospasm pain in throat or chest have been reported.

Management of Overdosage: Manifestations include somnolence, confusion, coma, diminished reflexes. Monitor respiration, pulse, blood pressure, employ general supportive measures, I.V. fluids, adequate airway. Use levarterenol or metaraminol for hypotension, caffeine and sodium benzoate for CNS-depressive effects. Dialysis is of limited value.

Supplied: Tablets, 2 mg, 5 mg and 10 mg bottles of 100 and 500. Tel-E-Dose® (unit dose) packages of 100, available in trays of 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10. Prescription Paks of 50, available singly and in trays of 10. Ampuls, 2 ml, boxes of 10. Vials, 10 ml, boxes of 1. Tel-E-Ject® (disposable syringes), 2 ml, boxes of 10. Each ml contains 5 mg diazepam, compounded with 40% propylene glycol, 10% ethyl alcohol, 5% sodium benzoate and benzoic acid as buffers, and 1.5% benzyl alcohol as preservative.



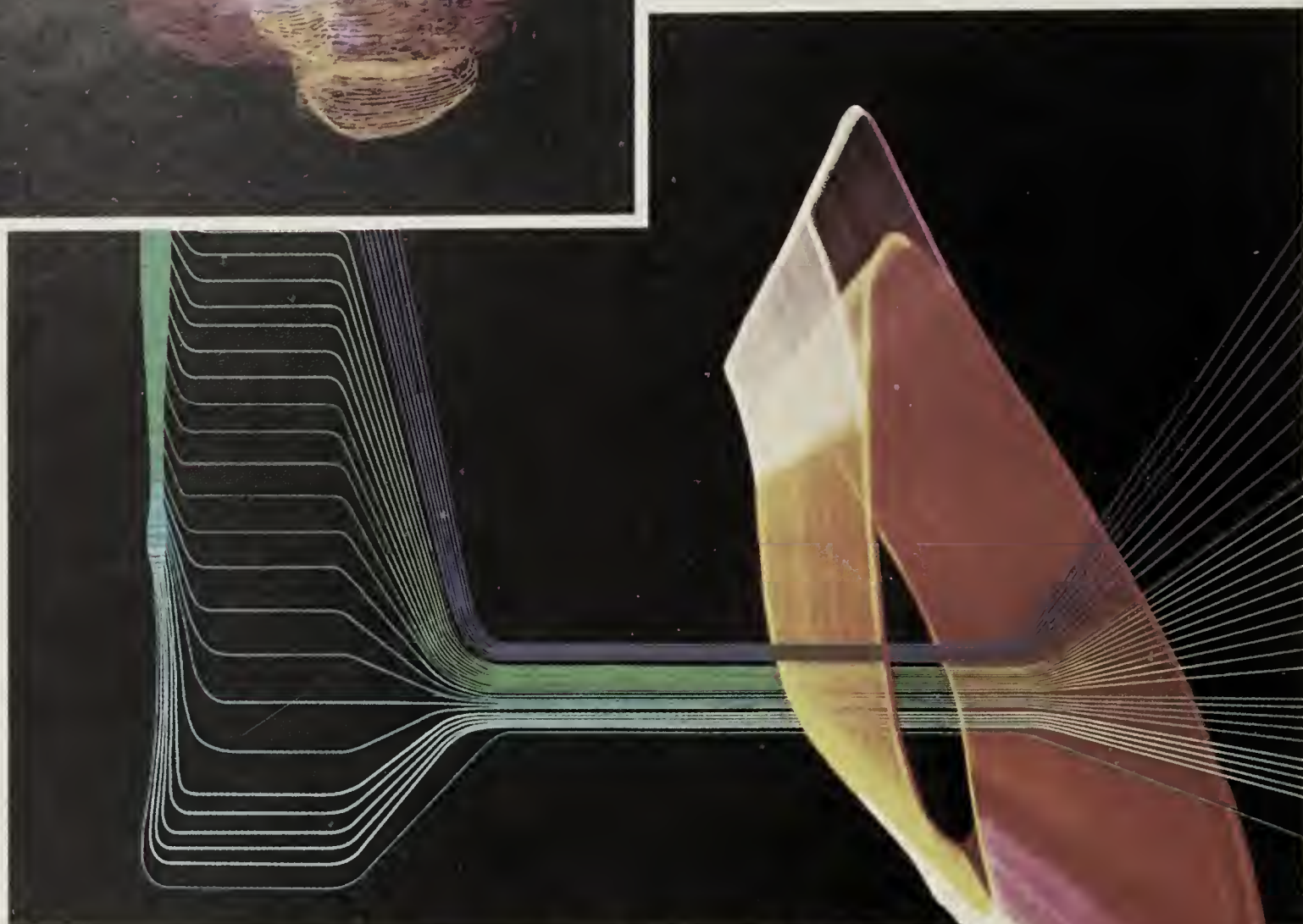
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MAR 17 1980

Breaking News for Michigan Doctors

MICHIGAN MEDICINE

Vol. 79, No. 6
February 22, 1980

MEDIGRAM

CAPSULES

THERE ARE APPROXIMATELY 15 Michigan specialty societies authorized to certify delegates to the 1980 MSMS House of Delegates which have not sent delegates' names to MSMS. MSMS needs those specialty society delegates' names soon for the April 25-27 event. Richard Campau is the contact at MSMS headquarters, 517/337-1351.

LAST CALL for the 1980 Michigan Conference on Maternal and Perinatal Health! Interested physicians are invited to the conference March 5-6 at the Hyatt Regency Dearborn. The meeting will award 11 hours of Category I credit and is accepted for 11 prescribed hours by the American Academy of Family Physicians. MSMS and eight other health care organizations are co-sponsors. A complete program and registration form are available from Katie Brewbaker at MSMS headquarters, 517/337-1351.

THE 1980 MSMS SPORTS MEDICINE CONFERENCE is planned April 10 at Long's Convention Center, Lansing, with concentration on running, swimming and tennis injuries, weight training and women in athletics. Edwin R. Guise, MD, Detroit Lions physician, is chairman. A registration form and complete meeting details appear in the Feb. 18 issue of Medigram. They also are available from Mert Scholten at MSMS headquarters, Box 950, East Lansing, 48823.

MSMS gathers debedding factions

On Feb. 18, MSMS brought together 45 persons deeply involved in the bed reduction process. MSMS President Ernest P. Griffin, Jr., MD, and MSMS Council Chairman Louis R. Zako, MD, invited factions of the bed reduction issue to MSMS headquarters for their first opportunity to share views on the controversial issue. Here are some sample comments:

- The Michigan Hospital Association representative said Medicaid funds could be used to reduce hospital beds, but the current planning process and its accompanying community involvement are a better way.
- The Detroit Medical Society, Wayne County Medical Society and Seven-County Health Planning Advisory Committee all called for rejection of the current bed reduction plan for the southeast Michigan area. The Seven-County Committee asked for a re-examination of the state's bed reduction formula and, if necessary, repeal of the Public Health Code section calling for plans to reduce excess hospital capacity. Kenneth J. Ray, MD, WCMS president-elect, said the current southeast Michigan plan is far more stringent than federal bed reduction guidelines.
- A Michigan Association of Community Hospitals and Physicians spokesman said the current southeast Michigan bed reduction plan shifts care from low-cost community hospitals to high cost referral hospitals. "We have no conflict with getting rid of unnecessary hospital beds," he said, "but the southeast Michigan plan totally perverts the (bed reduction) bill."
- The Office of Health and Medical Affairs director asked the group to consider what would happen if the current southeast Michigan plan is not adopted. He pointed out the responsibility for a bed reduction plan then would shift to the Statewide Health Coordinating Council, and ultimately to the Michigan Department of Public Health.
- The chairman of the House Public Health Committee said he is concerned by City of Detroit unemployment that may result from the bed reduction plan, and the plan's impact on small hospitals. Other speakers represented members of the Health Care Cost Containment Coalition, including Ford Motor Company, the UAW, and Blue Cross Blue Shield of Michigan.

CAPSULES/continued

THERE STILL ARE 375 MDs who have not renewed their Michigan licenses. The deadline for application for license renewal was Dec. 31.

Physicians who fail to renew licenses may lose all third party payments as of Jan. 1. Medicaid, for instance, will not pay for any services rendered since the first of the year if a physician has not renewed by Feb. 29. Physicians whose licenses have lapsed have problems in other areas, such as hospital privileges. Physicians who have not renewed their licenses should immediately contact the Board of Medicine, 517/373-0680.

THE 1978 NOBEL LAUREATE for medicine will speak at the Wayne County Medical Society's annual Beaumont Lecture April 7 at Henry Ford Hospital. Hamilton O. Smith, MD, Department of Microbiology, Johns Hopkins University, will discuss "Restrictive enzymes as tools for genetic research." Please contact WCMS headquarters, 1010 Antietam, Detroit, 48207 (313/567-1640).

Brown McNeely extension requires reporting

The Senate Insurance Committee has sent to the floor legislation to extend the Brown-McNeely state malpractice insurance fund until Dec. 31, 1981, with the additional requirement the fund report quarterly to legislative insurance committees on its progress toward termination. This is the second extension granted the fund, but the first time the Legislature has written language requiring the reporting. Senate floor action and House approval remain before the bill becomes law...The Senate Insurance Committee also began section-by-section review of HB 4555, the Blue Cross Blue Shield reform bill. Among first items it considered was MSMS language to clarify the continuance of per case participation. A vote is likely next week. In other developments....Legislation introduced by Rep. Larry Burkhalter (D-Lapeer) would require physicians to inform patients whether they are participating physicians in Blue Cross Blue Shield of Michigan. House Bill 5456 was referred to the House Committee on Consumers for study....

New MDPH rules still separate private offices, surgical clinics

The Joint Administrative Rules Committee Feb. 12 adopted rules proposed by the Department of Public Health to separate free-standing surgical outpatient facilities from private practice offices for purposes of state regulation. The main characteristic which differentiates the two is whether the facility or office is used "primarily for the purpose of performing surgical procedures." Despite strong attempts to rule that either facility or office could be regulated according to a strict percentage of surgical procedures performed, MSMS was successful in retaining the more flexible language.

Michigan State Medical Society
120 West Saginaw Street
East Lansing, Michigan 48823

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Editor: Judith Marr

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APR 15 1980

Breaking News for Michigan Doctors

MICHIGAN
MEDICINE

Vol. 79, No. 7
March 20, 1980

MEDIGRAM

CAPSULES

MSMS COUNCILOR CONFERENCES are underway for the April 25-27 MSMS House of Delegates meeting. The conferences bring MSMS delegates together with their councilors to discuss the major issues of the coming session. Subjects this year include bed reduction, the Federal Trade Commission, Medicaid, Blue Cross Blue Shield of Michigan reform legislation, and professional liability insurance. The conferences scheduled are as follows:

March 20--The Fogcutter, Port Huron; April 2--Park Place Motor Inn, Traverse City; April 5--Chippewa Club, Iron Mountain; April 8--Peninsular Club, Grand Rapids; April 9--Century Club, Muskegon; April 9--Win Schuler's, Kalamazoo; April 10--The Troy Hilton, Troy; April 16--Bay Valley Motor Inn, Bay City; April 17--Win Schuler's, Jackson; April 23--University Club, Flint.

SAMUEL GERSHON, MD, has a license to practice medicine in Michigan and has officially undertaken his duties as director of Lafayette Clinic in Detroit. Doctor Gershon, an Australian-born psycho-pharmacologist, is settling into his new duties following special legislation which recognizes his unique qualifications to perform as head of the giant research center. MSMS supported the special legislation in order to bring Gershon to Michigan.

Board of Medicine granted Gershon a clinical license.

MSMS calls for moratorium on bed reduction plans

MSMS has asked the Comprehensive Health Planning Council of Southeast Michigan to join in calling for a moratorium on state bed reduction plans. John R. Ylvisaker, MD, Pontiac, MSMS president-elect, asked for the joint action at a public hearing on the bed reduction issues held March 14 by the CHPC-SEM. The MSMS Council had voted to seek the moratorium at its regular March 5 session.

Doctor Ylvisaker said "the negative impact (of the plan) on the black community and other minorities, the underprivileged, physicians and other hospital personnel, and medical education programs, can be averted by permitting adequate time for the development of a bed reduction plan that is sensitive to these issues."

Letters have gone from MSMS offices to key legislators telling them of the Council's wish for a moratorium on actions resulting from the bed reduction legislation.

Also testifying against the bed reduction plan at the March 14 hearing were representatives of the Wayne County Medical Society, the Seven-County Physicians Health Planning Advisory Committee, and the Michigan Society of Obstetricians and Gynecologists.

Preceding the hearing, MSMS held a news conference to emphasize its position on the bed reduction plan. Detroit media outlets and interested hospital people heard statements from James Fryfogle, MD, representing MSMS; George Lightbourn, MD, representing the Detroit Medical Society and George Gerber, MD, representing Michigan obstetricians and gynecologists. Both Doctors Fryfogle and Ylvisaker did TV interviews on the topic later in the day.

TWO MSMS MEMBERS are scheduled to be guests on coming segments of the WJR radio talk show, "Focus." Host J. P. McCarthy of the popular Detroit program will speak with James D. Fryfogle, MD, Speaker, MSMS House of Delegates, on the April 3 noon show, while his guest for the April 7 program will be Edwin R. Guise, MD, chairman, MSMS Sports Medicine Conference. Doctor Fryfogle's topic will be the current bed reduction issue, and Doctor Guise's will be the conference.

BROOKER MASTERS, MD, a member of the MSMS delegation to the AMA House of Delegates for 10 years, has said he will not run for re-election. In his announcement, Doctor Masters said other pressing medical matters cause him to step down from the delegation, adding, "This has been a tough decision to make, for organized medicine has been a major factor in my life for many years." Doctor Masters served on The Council from 1963 to 1972, was chairman in 1972, and was president of MSMS in 1973-74.

MSMS Council highlights

At its regular March 5 meeting, the MSMS Council:

- 1) Called for a moratorium on plans to reduce hospital beds for cost containment. The Council voted to seek the moratorium following recommendations of a position paper called for at the Council's previous meeting. The Council also directed its statement requesting a moratorium be presented in Detroit on March 14 at a public hearing on the bed reduction issues. (see related story on page 1.)
- 2) Endorsed the concept of hospice programs as having an appropriate and humane role in the case of the terminally ill. The Council referred the issue of hospice legislation to the MSMS Committee on State Legislation and Regulations for monitoring and assurance of quality control in legislation which may be enacted, and authorized a financial contribution of \$500 to the Michigan Hospice Organization.
- 3) Approved a booklet, "The Physician's Guide to Selected Patient Charges and Hospital Reimbursement," prepared jointly by MSMS Task Force on Medical Care Costs and the Michigan Hospital Association Committee on Cost Containment. The booklet is designed as a useful tool to increase the awareness of the medical staff to the charges experienced by hospitalized patients. MHA will handle the printing and distribution.

Register now for Sports Conference

100 early registrations are in for the 1980 MSMS Sports Medicine Conference, April 10 at Long's Convention Center, Lansing. Team physicians, coaches and trainers are urged to register now for the popular event. Please contact Merv Scholten, MSMS headquarters, 517/337-1351.

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MICHIGAN MEDICINE

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MICHIGAN MEDICINE

March 1980

JOURNAL OF THE MICHIGAN STATE MEDICAL SOCIETY

Vol. 79, No. 8

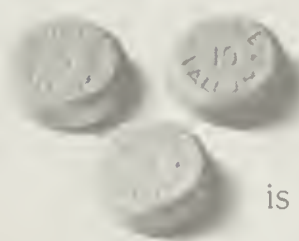


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Valium (diazepam/Roche)
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Pharmacologically, it is a potent skeletal muscle relaxant and anticonvulsant (in adjunctive use), as well as an antianxiety agent. Pharmacokinetically, only Valium provides active *diazepam* as well as the active metabolites 3-hydroxydiazepam, desmethyldiazepam and oxazepam.

But the individual character of Valium is even more apparent clinically than pharmacokinetically. And far more significant. That's because of the patient response obtained with Valium. A response which brings a calmer frame of mind. A response which has a pronounced effect on the somatic symptoms of anxiety, particularly muscular tension. A response which helps the patient feel more like himself again because of the way Valium reduces the overwhelming symptoms of anxiety and psychic tension.

Another important aspect of the clinical character of Valium is safety. Though drowsiness, ataxia and fatigue are possible, these and more serious side effects are rarely a problem. Of course, as with all CNS-acting drugs, patients taking Valium should be cautioned against driving, operating dangerous machinery or the simultaneous ingestion of alcohol.

Unquestionably, many psychotherapeutic agents, including other benzodiazepines, have antianxiety effects. But one fact remains: you get a certain kind of patient response with Valium. It's a response you want. A response you know. A response you trust as part of your overall management of anxiety and psychic tension.

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Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology; spasticity caused by upper motor neuron disorders; athetosis; stiff-man syndrome; convulsive disorders (not for sole therapy).

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Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

Dosage: Individualize for maximum beneficial effect. *Adults:* Tension, anxiety and psychoneurotic states, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. *Geriatric or debilitated patients:* 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) *Children:* 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

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Patients at Cottage Hospital, Grosse Pointe Farms, demonstrate their concern with the bed reduction situation. This month's special report provides background, a description of what is proposed to date, and involved physicians' views of how bed reduction plans are working. (*Michigan Medicine* photo by Mert Scholten, MSMS staff)

MICHIGAN MEDICINE

March 1980, Volume 79, Number 8

Special report

- 108** The state's requirement that hospital beds be reduced is a hot controversy in parts of Michigan. This *Michigan Medicine* special report provides the history of the bed reduction requirements, describes how each health service area is affected, and allows several involved Michigan physicians to comment on the effectiveness of the current bed reduction plans; Dennis Paradis, James D. Fryfogle, MD, Andrew D. Hunt Jr., MD, Richard L. Rapport, MD, Charles O. Seifert, MD, Robert J. Toteff, MD, Myron Wegman, MD, Elliot K. Wicks, PhD, and Hermann A. Ziel, Jr., MD

Two special desk reference cards, prepared by the Michigan Heart Association, are published with this issue. (See pages 135-138.) The subjects are screening for cardiac disease in the young, and pediatric hypertension. Michigan physicians are encouraged to remove these desk reference cards from the magazine and file them for handy reference.

Features

- 123** Retiring BCBSM Vice President for Professional Affairs Louis F. Hayes, MD, reflects on the past 12 years; Shelton Reece
- 126** BCBSM President John C. McCabe answers charges which have inspired the current drive for reform of the Blues; Willah Weddon
- 128** Michigan ophthalmologists stage media campaign to fight off encroachments of optometrists; Philip C. Hessburg, MD, and Justin L. Moran
- 135** Michigan Heart Association Desk Reference cards
- 143** MSMS survey shows large increase in Michigan malpractice claims; John Richards
- 146** Michigan Physicians Mutual Liability Company has unique features tailored to state's MDs; Martha Smith
- 162** The Michigan Department of Management and Budget; Sherry Nolte Wellman
- 166** Marquette County Medical Society's activities; William A. Mudge, Jr., MD

Departments

- 104** Editorial
- 106** Letters
- 118** Health Planning Update
- 148** Business
- 150** MSMS/A
- 152** News
- 153** New members
- 153** Ad index
- 154** MSMS Q/A
- 167** Meetings
- 168** Category I courses
- 172** Deaths
- 173** Classified ads
- 174** President's page

MSMS working for members in controversial debedding issue

Michigan law requires the elimination of 3,800 excess hospital beds in the state.

MSMS has been watching the process with intense interest, as it will affect the delivery of health care in many ways. Obviously, there is much controversy over this state-legislated program, particularly in southeast Michigan, where the state identified 2,529 beds to be eliminated.

MSMS is working hard to promote the interests of several physician groups directly concerned with the debedding issue. Among the approaches the state society is taking are these:

- The MSMS Physician/HSA Support Center staff is focusing on the subject. Health systems agencies are responsible to write the plans for reducing hospital beds in their areas, and the MSMS support center's purpose is to work with the physicians who serve on the HSA boards.

- MSMS brought together the leaders of the debedding factions in a unique encounter at MSMS headquarters. It allowed legislators, health planners, physicians, hospital administrators, bureaucrats, auto company and UAW representatives to describe personally to each other their goals and feelings in the debedding issue.

- MSMS has written its own position paper on bed reduction, which was to go to the MSMS Council March 5 for approval. MSMS then will use this position to promote the interests of all its members.

MSMS represents the black physicians of inner city Detroit and the suburban MDs of Grosse Pointe, whose hospitals may close when their beds are reduced in numbers. MSMS also represents the Cheboygan physician who has little concern about the debedding program because there are no excess hospital beds in the northern lower peninsula.

With such diverse interests to represent, MSMS has carefully studied and worked to help MSMS members all over the state better understand the issue. Articles on pages 108-116 of this *Michigan Medicine* describe the history of the debedding issue in Michigan, briefly explain how each service area of Michigan is affected, and allow MSMS members close to the controversy to express their positions.

Thus MSMS works to establish an informed, constructive stance on the debedding issue. MSMS members should best be served by their society in this manner.

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Michigan Medicine, the official journal of the Michigan State Society, is dedicated to provide useful information for Michigan physicians about actions of the Michigan State Medical Society and contemporary issues, with special emphasis on socio-economics, legislation and news about medicine in Michigan. Major medical developments will be reported and interpreted as has been the custom.

The Michigan State Medical Society Committee on Publications is the editorial board of *Michigan Medicine* and advises the editors in the conduct and policy of the magazine, subject to the policies of the MSMS Council.

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DESCRIPTION: Methyltestosterone is 17 β -Hydroxy-17-Methylandrosterone-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunuchism 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-puberal cryptorchidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric,

avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE**

REACTIONS: Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. **In the male:** Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpuberal cryptorchism, 30 mg. **REFERENCE:** R. B. Greenblatt, M.D.; R. Witherington, M.D.; I. B. Sipahioglu, M.D.: Hormones for Improved Sexuality in the Male and the Female Climacteric. *Drug Therapy*, Sept. 1976. **SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only.

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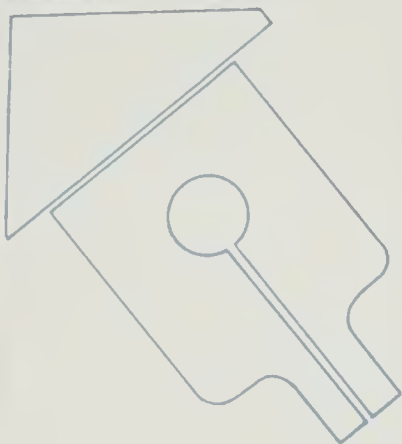
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Michigan Medicine aids patient search

Please find enclosed two additional requests for patients for studies in the Clinical Research Center at the University of Michigan for publication in *Michigan Medicine*. (See page 164.)

I have seen the initial publication of two requests for patients in the December issue of *Michigan Medicine*. They look great! Dr. Marshall reports that he has already received eight telephone inquiries and this has resulted in four new patients entering his study. This is an excellent response from our point of view.

Sincerely,

Irving H. Fox, MD
Director
Clinical Research Center
University Hospital, Ann Arbor

Addendum

Eugene C. Strauss, MD, whose license was suspended recently by the Michigan Board of Medicine (as reported in the January 1980 *Michigan Medicine*) has never been an employee of this medical center, was never appointed as a member of the consulting or full-time medical staff, and had no activities related to patient care or treatment.

James R. Donachie
Medical Center Director
VA Medical Center
Battle Creek

U.S. should quit poaching physicians of less-developed countries

Shelton Reece's article "Needed: A reasonable system for FMGs to study, work in US" highlights the chauvinism that has undermined US immigration policy for a generation. Certainly, FMGs have "filled a vast void in the health care delivery system of this nation" — but for every hole plugged here, a gaping one has been left in the country of origin. The United States receives physicians who are ready to go to work, or nearly so, while the country of origin (often much less wealthy than the US) has borne the costs of rearing and educating the doctor. Little wonder that a UN publication termed the whole process "a gift from the needy."¹

Doctor Silva is quoted as saying that "it would be very unfortunate if our laws became so restrictive that the US failed to help educate physicians

¹*The Interdependent*, Vol. 1, No. 2, May 1974

Brochures available on children's heart problems

The Heart Disease of the Young Committee of the Michigan Heart Association would like to inform MSMS members that many publications are available on this subject which might be helpful in their practice.

Some are helpful to hand out to parents, others for reference. The "Bibliography of Publications for Health Care Consumers" was recently revised to a list of 24 publications.

To obtain sample copies of these publications, contact the Michigan Heart Association Regional Office or Heart Information Center in your area (check your local telephone directory for listing).

Martin K. Wyngaarden, MD
Chairman, Heart Disease in the
Young Committee
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16310 W. 12 Mile Rd.
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trained in other countries where their services desperately are needed." Agreed, but this does not automatically translate into bringing such physicians to the United States for training. In fact, that system has proved unsuccessful in the extreme since some two-thirds of these physicians remain in the US rather than returning to those "other countries where their services desperately are needed." The training should take place outside the United States, preferably in institutes established in the home countries or regions, and should be confined to technology appropriate to the level of development of the medical system in the country of origin.

The final quote from Doctor Silva concludes "there should be some equitable way to allow a reasonable number of FMGs to come into the country to study and, if needed, for some of them to stay, if they so desire." Let's be honest with ourselves. People stay not because they're needed, but because they "so desire." Congress settled the question of need, at least in a legal sense, when it made a legislative finding of fact in the Health Manpower Act of 1976 that there were sufficient physicians in the United States. The Labor Department responded by removing physicians from the list of occupations for whom preferential immigration visas were available.

If the United States needs additional physicians, it should train its own residents, and pay the costs involved. We should quit poaching on the preserves of our less-developed brethren, all the while patting ourselves on the back for our "liberal" immigration policy.

Sincerely yours,

John H. Tanton, MD, Chairman
Federation for American
Immigration Reform
Petoskey

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They're in their late sixties, the beneficiaries of more liberal retirement laws and more enlightened attitudes toward the elderly. They're leading socially productive lives. But recently, without any clear cause, they had each begun to experience mild episodes of symptoms such as confusion, mood-depression, and dizziness. Their ability to function could have been jeopardized. That's when they became the beneficiaries of oral Hydergine therapy.



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Bed reduction in Michigan a complex, controversial issue

By Dennis Paradis, Director
MSMS Physician/HSA Support Center



Articles in this *Michigan Medicine* special report outline the bed reduction plans proposed for the six targeted areas of the state, describe the origins and development of the bed reduction concept, and provide Michigan physicians with a chance to spout off on the whole idea.

The excess hospital bed reduction program had its genesis in 1976.

The Appropriations Committee of the Michigan House of Representatives, alarmed over the dramatic increases in the Medicaid program, was searching for cost containment measures.

Because the auto industry had parallel concerns about increases in health insurance rates, it joined the Legislature to identify strategies for cost containment in the health field. Their dialogue developed into a coalition of the Big Three auto manufacturers, Blue Cross Blue Shield of Michigan, the United Auto Workers and members of the legislature.

The coalition determined the increase in Medicaid costs was a reflection of the increase in the cost of health care as a whole.

Because hospital costs account for about 40 percent of the health care dollar, and because hospital costs were the most rapidly rising component of health care expenditures, the coalition felt cost containment in the hospital sector would be the most productive strategy.

The coalition determined the elimination of "excess" hospital beds would result in significant savings without lowering the quality of health care. By restricting the hospital bed supply, the coalition projected it would eliminate overhead costs and reduce hospital use.

Based on the coalition's position, new legislation called on the Michigan Department of Public Health to determine the number and location of excess hospital beds (HB 4491 of 1977) and to eliminate these beds through the licensing mechanism (HB 4487 of 1977).

The legislature's sense of urgency, combined with the coalition's political clout, made it impossible to defeat the concept of bed reduction.

However, every aspect of the bed reduction process was intensely debated in legislative and health planning arenas.

The outcome was quite different than the initial proposal. Instead of focusing bed reduction at the state level, a series of checks and balances assured no single faction could control this controversial program.

For example:

- Legislators determined the actual number of excess beds (3,800). This number is drastically reduced from the initial estimate of up to 7,000 excess beds projected by the coalition.

- The Michigan Department of Public Health determined the location of the excess beds.

- The Statewide Health Coordinating Council developed guidelines

to identify excess beds. These guidelines are reviewed annually by a legislative committee.

- Health Systems Agencies (HSAs) are responsible to develop bed reduction plans. This approach gives hospitals, doctors and residents some voice in the changes that will occur in their communities. If the HSA does not develop a suitable plan, the state does it.

- The MDPH is responsible to enforce the program by denying certificate of need requests not consistent with the bed reduction plans.

- A governor's task force must address the financial and legal issues in bed reduction. These areas are considered so crucial that the bed reduction program is not to be enforced unless the report of the Governor's Task Force is approved.

With this series of safeguards, the excess bed reduction legislation passed as part of the Certificate of Need section of the Public Health Code (PA 368 of 1978).

Where are we now?

Six of the state's eight HSAs have excess hospital beds, according to the program. Their bed reduction responsibilities are as follows:

Greater Detroit area	2,412 excess beds (14.0% of total)
Lansing area	86 excess beds (5% of total)
Kalamazoo area	41 excess beds (4% of total)
Battle Creek area	136 excess beds (18% of total)

Muskegon area	87 excess beds (10% of total)
Flint area	387 excess beds (22% of total)
Saginaw area	165 excess beds (14% of total)
Bay City area	58 excess beds (10% of total)

HSA's had 210 days to develop bed reduction plans suitable to the Statewide Health Coordinating Council (SHCC). These plans were due on Dec. 21. All six HSA's submitted bed reduction plans on schedule, but the SHCC returned the plans for the Flint and Detroit areas for more development. Both plans are due back to the SHCC on March 31.

At the same time the HSA's were developing bed reduction plans, the Governor's Task Force on Excess Hospital Capacity Reduction was meeting to debate the legal and financial aspects of hospital bed reduction. The Governor's Task Force published a two-volume report in December of 1979. Some of the issues addressed by this task force are: physician dislocation problems caused by bed reduction, the problems of resulting unemployment and financial mechanisms to assist in hospital bed reduction.

What is the response?

The response to the bed reduction plan varies with each community. Not unexpectedly, the level of controversy rises in direct proportion to the size of the problem. Although the most con-

troversial bed reduction plans are still in their respective HSA's, there are many criticisms:

- Impact on small hospitals. It is argued the bed reduction process is essentially political and the larger, politically stronger hospitals will survive while the smaller, politically weaker hospitals will be sacrificed. The smaller community hospitals feel they have an important role in the health care delivery system.

- Impact on osteopathic training programs. The bed reduction plans fall heavily on osteopathic hospitals. The osteopathic profession fears this will adversely affect its ability to be accredited by the American Osteopathic Association to provide graduate medical education programs. This is a major concern because more than 15 percent of all osteopathic graduate medical education programs are in Michigan.

- Impact on access to health care. The formula for hospital bed need is based on 1,000 days of medical/surgical utilization per 1,000 persons. Some areas of the state use considerably more than 1,000 days. For instance, the inner city of Detroit used about 1,400 days of medical/surgical care per 1,000 population. Some are concerned that reducing the hospital bed supply to 1,000 medical/surgical days of care per 1,000 population will create a shortage in those areas with higher rates.

Physician involvement

The coalition did not invite MSMS to participate in developing the

bed reduction legislation. But MSMS was very active in the efforts to change the legislation and the subsequent criteria and guidelines in order to permit greater participation at the community level.

The actual impact of the bed reduction program could not be determined until the bed reduction plans were written. Now that the bed reduction plans are available, the MSMS Council has directed the Steering Committee on Health Planning to prepare a position paper. The MSMS council will deliberate this paper at its March 5 meeting.

How eight Michigan HSAs are affected



Map delineating Michigan's HSA regions.

The following outlines of Michigan's six bed reduction plans are from the report prepared by MSMS staff and presented Jan. 31 to the MSMS Council. According to the formula approved by the Statewide Health Coordinating Council, the Upper Peninsula and Northern Michigan health service areas did not have excess beds, and thus did not have to prepare bed reduction plans. They, therefore, are omitted from this report.

East Central Michigan

Saginaw Subarea

Number of beds to be reduced 165
(14 percent of total beds)

Area affected Saginaw County
Hospitals affected 4

The Saginaw subarea will reduce 165 acute-care hospital beds through two separate but concurrent consolidation actions.

First, during the 18 months after final approval of this plan, Saginaw General and St. Luke's hospitals will consolidate and identify 105 specific beds to be reduced. Second, all four hospitals (Saginaw General, St. Luke's, St. Mary's and Saginaw Osteopathic) will consolidate major clinical services to reduce 60 acute-care beds in Saginaw Osteopathic and St. Mary's hospitals.

Most of the 221 practitioners who admit patients to any of the four Saginaw hospitals have staff status at, and use, two or more of the four hospitals. Thus, the consolidations are not expected to have any major or adverse impact on physician staff privileges.

The proposed realignment and adjustment of hospital services within the Saginaw Subarea should have little or no effect on the education and training programs currently provided.

The physicians in the Saginaw area have adopted a "wait and see" attitude concerning the bed reduction plan. The proposed mergers are not detrimental to the health care delivery system, but the physician community is skeptical as to whether these mergers will occur.

Bay Subarea

Number of beds to be reduced 58
(10 percent of total beds)

Area affected Bay and Arenac
Counties

Hospitals affected 4

The Bay subarea will eliminate 58 acute-care hospital beds in two phases including a consolidation of hospitals. During the 18 months after final approval of this Plan, Bay City Samaritan Hospital and Bay Medical Center will consolidate and identify 15 beds to be eliminated in 1982-83. Bay Osteopathic Hospital will reduce six pediatric beds in 1982, and five adult medical/surgical and four obstetric beds in 1983. Standish Community Hospital will reduce one obstetric bed each in 1982 and 1983. The remaining 26 beds will be reduced as the plan is developed.

The hospitals and the ECMHSA also will evaluate the effects of the hospital consolidations on use by area practitioners.

The Bay/Arenac/Iosco County Medical Society has not formally commented on the Bay subarea bed reduction plan.

Comprehensive Health Planning Council of South East Michigan

State total for CHPC-SEM 2,412
(14.6 percent)

CHPC total 2,936
(17.8 percent)

Area affected Wayne, Oakland,
Macomb Counties

Hospitals affected 61

SEM to reduce 2,412 hospital beds from six service areas in Wayne, Oakland and Macomb Counties. CHPC determined there are an additional 524 excess hospital beds.

CHPC-SEM established 51 criteria by which to evaluate hospital performance. The point system was weighted to reflect the importance of the criteria.

The low scoring and mid-range hospitals will be responsible to reduce the total number of state designated excess hospital beds (2,412). Group III hospitals will be encouraged to reduce beds to achieve the additional target of 524 beds established by the CHPC-SEM Commission. The disposition of these 524 beds currently is being debated by the CHPC-SEM.

Because economically poor populations utilize more hospital days, CHPC-SEM added a factor to the bed reduction calculations to retain beds in areas with a high percentage of poor persons. That reduces bed reduction for the inner city of Detroit by 138 beds. The 138 beds were added to the bed reduction counts of the other five service areas.

Since its adoption by CHPC-SEM, the Bed Reduction Plan has undergone one important modification. Martin Place Hospital obtained an injunction prohibiting CHPC-SEM from submitting a bed reduction plan to the Statewide Health Coordinating Council mentioning the hospital. CHPC-SEM thus submitted its plan with all references to the hospital deleted. Martin Place Hospital will be reinserted in the bed reduction plan at

such time as the injunction is resolved.

There are two major concerns about the effect of the CHPC-SEM Bed Reduction Plan on health manpower:

1. Osteopathic physicians have said the CHPC-SEM bed reduction plan would seriously damage their ability to provide graduate medical education, as 22 percent of the total DO beds are scheduled to be eliminated, as compared to 14 percent of the total allopathic beds.

2. Because the CHPC-SEM Plan will close down small hospitals, inner-city hospitals will be heavily affected. Inner-city physicians contend they will not be granted privileges at the remaining hospitals and will be forced to relocate their practices. This will leave the inner-city residents with fewer physicians to meet their health care needs.

The Seven County Health Planning Advisory Committee is concerned:

1. Whether the plan actually will reduce health care costs.

2. That the subjective criteria and hospital ranking system are not consistent with a logical allocation of bed reduction responsibilities.

3. With inappropriate criteria by which hospitals were evaluated.

4. With effect on residents in the inner-city area.

5. With impact on osteopathic graduate medical education programs.

6. With the effect of unemployment in the city of Detroit.

7. With the threat to the continued existence of small community hospitals.



This photo was part of Cottage Hospital, Grosse Pointe Farms, campaign against bed reduction.

State legislation charged CHPC-

SPECIAL REPORT/continued

Genesee-Lapeer-Shiawassee

Number of beds to be reduced 387
(22 percent of total beds)
Area affected Genesee County
Hospitals affected 7

GLS-HSA worked with the Greater Flint Area Hospital Assembly to produce criteria for measuring hospitals and a bed reduction plan.

Simultaneously, a formula for adult and pediatric medical/surgical use was applied to each hospital. This formula determined the number of beds to be eliminated from each facility. The total bed reduction responsibility was then spread over the five-year planning schedule.

The GLS-HSA Plan does not call for elimination of any hospital beds until 1984. Until then the beds targeted for reduction will not be used. It is the responsibility of the PSRO to monitor the hospitals to assure the "deactivated" beds are not being used, according to the plan.

The key to success in the GLS-HSA bed reduction plan is reducing the medical/surgical use rates. Because the number of OB beds for Genesee County is consistent with the state's determination of bed need, only medical/surgical beds are to be reduced. In an effort to reduce medical/surgical utilization, the Greater Flint Area Hospital Assembly has prepared a program entitled "Reduce Utilization Now" (RUN). This program will be conducted simultaneously with the bed reduction program.

The Genesee County Medical Society's bed reduction committee issued a position paper saying there is a slight excess of hospital beds in Flint but these beds should not be delicensed. The committee also said the bed reduction plan will not result in significant cost containment.

Most importantly, the committee felt elimination of 387 hospital beds would create a rationing situation for health care. For these reasons, Flint area physicians are opposed to the reduction of hospital beds in Genesee County. The committee suggests several alternatives to lower health care costs.

Michigan Mid-South

State total 86
MMSHSA total 90

Area affected Ingham County
Hospitals affected 2

MMSHSA and area hospitals already were working to reduce excess capacity before finalization of the SHCC's Guidelines and Criteria. A condition placed on a Michigan Department of Public Health certificate of need approval for the \$32 million expansion program at Sparrow Hospital in Lansing in 1978 directed that facility to negotiate to purchase the under-used adjacent Provincial Hospital. Sparrow purchased the Provincial facility, closed 90 of its 96 beds, and added the remaining six beds to Sparrow's obstetrical complement, as of Aug. 6, 1979. The MMSHSA Board of Trustees on Oct. 10 approved the plan.

MMSHSA projects \$2.1 million will be saved from closing the 90 beds, and an additional \$2.7 million will be saved from scaled-down or obsolete certificates of need previously granted to the two hospitals.

The physician members of the MMSHSA Board of Trustees approved the MMSHSA bed reduction plan without conditions.

Southwest Michigan

Kalamazoo Subarea

Number of beds to be reduced 47
(4 percent of total beds)
Area affected Kalamazoo County
Hospitals affected 5

Forty-seven hospital beds in the Kalamazoo area will be reduced, and a comprehensive system of shared services developed, to be governed through a Kalamazoo Service Area Health Care Authority. This authority will include a Citizens Advisory Committee which will work with a Kalamazoo Service Area Council of the SWMHSA in establishing and implementing a policy for shared services.

Twelve months from the approval of the bed reduction plan by the SHCC, the five hospitals plan to have the composition and operating guidelines for the authority. These guidelines will provide the authority with the capacity to enforce shared service plans.

Eighteen months after the approval of the plan the authority will be functioning. Twenty-four months after the initial approval, the Authority will have developed a formal plan for a comprehensive system of shared

services, such as computer services, admissions, laundry and purchasing.

This system will include the reduction of the hospital beds.

Battle Creek/Marshall Subarea

Number of beds to be reduced 136
(18 percent of total beds)
Hospitals affected 5

The reduction of 136 beds in the Battle Creek/Marshall area will be accomplished through consolidations.

The SWMHSA says this plan is not expected to have any major or adverse impact on physician staff privileges in the area, nor adversely affect any of the education or training programs sponsored by the Kalamazoo area hospitals.

The Battle Creek/Marshall bed reduction plan includes a common medical staff credentials committee for all hospitals in the region.

West Michigan

Number of beds to be reduced 87
(10 percent of total beds)
Area affected Muskegon and
Ottawa Counties
Number of hospitals affected 5

The plan identifies 87 beds to be reduced. First, Heritage Hospital will eliminate all of its 46 acute care beds before 1982 through consolidation with another hospital or through closure.

Second, the remaining hospital beds will be eliminated by 1984 as follows: Hackley — 12 beds; Mercy — 10 beds; Muskegon General — 10 beds; and North Ottawa Community — nine beds. In 1982 or 1983, the planned bed reduction will be reassessed following redistribution of Heritage Hospital patients.

The West Michigan Health Systems Agency estimates savings of \$1,130,000 annually from closing Heritage Hospital. The WMHSA speculates reduced hospital use due to a smaller supply of beds could result in additional savings of \$1,765,000 per year.

The plan is expected to have limited negative impact on inpatient services, physician staff privileges, unemployment among other personnel and other areas of concern. There should be no other impact on physician staff privileges in the area.

How Michigan physicians see it:

Michigan Medicine asked several involved Michigan physicians whether they think the bed reduction plans actually will save any money and what they think about the bed reduction concept now that it's being carried out. Here are their remarks:

James D. Fryfogle, MD, Southfield

"Debedding is a term of the Health Care Cost Containment Coalition.

There was no contribution from organized medicine, from hospital associations, or from consumer groups other than union organizations when the coalition's debedding legislation was written in 1974.

The coalition's theme was simple — cut out 4,500 excess beds from Michigan's hospital bed census and cut the costs of paying for them.

It seems to me members of the coalition only pay for hospital beds; they don't use them to care for sick patients. No details of this cost cutting plan (sick patients needing a hospital bed might call it rationing) were made available. Thus this straight-forward logic became HB 4491 and was quickly passed by both the Michigan House and Senate. I fully believe the legislators who

sponsored this bill had no knowledge of the serious problems its passage would make for their constituents.

HB 4491 then became Section 22154 of PA 368, the new Public Health Code — but again no details of its implementation were included.

I chair the Seven County Health Planning Advisory Committee, a group of knowledgeable, dedicated physicians representing the seven county medical societies, the osteopathic societies and the Detroit Medical Society of southeast Michigan, where the debedding action falls heavily.

On the debedding issue we have gone the full cycle, from learning and trying to help with the plans to voting opposition.

The jagged edge of the debedding axe slashing through our present system disrupts continuity of care, substitutes expensive for low

cost beds, displaces physicians and their patients, makes hospital employees jobless, causes an undesirable impact on graduate education and makes no promises of improvement in the system of quality care or its accessibility.

I think debedding is a bad hill. I urge your cooperation in working for the repeal of Section 22154 of PA 368.

Doctor Fryfogle is chairman of the Seven County Health Planning Advisory Committee.



Andrew D. Hunt, Jr., MD, East Lansing

The bed reduction process currently in motion is stressful, often tumultuous, and of deep concern to practicing physicians in many Michigan communities.

So far, the consistent position of the SHCC has been that the assigned bed reduction quotas have been developed fairly and that it is within the abilities of the various HSAs equitably to assign required reductions to specific institutions. Turbulence and some unhappiness is expected to continue.

There is no doubt that decreasing hospital utilization decreases cost and that it is often in the best interest of patient care. Nor is there doubt that laboratory and other diagnostic and treatment services tend to be over-used, with documentation beginning to appear with increasing frequency.

Hospital bed reduction is one tool

available to agencies such as HSAs and state health coordinating councils and should have tangible cost-reducing effects.

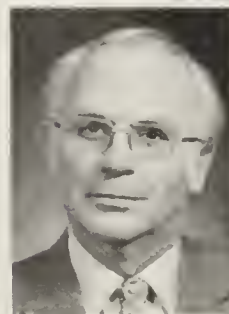
The real issue, however, lies in the way medicine is practiced, since the physician essentially controls the entire apparatus of medical care. It could be that the best medical care more often than not is that which is least invasive, least uncomfortable to the patient, most conducive to maintenance of normal living conditions and specifically oriented around individual patients and their illnesses.

Careful, selective attention to limiting laboratory work and medical ministrations to those mandated by individual patient needs rather than extensive utilization in the interest of exhaustive exploration of disease processes could both improve the quality of patient care and the relationships between our profession and

the public.

Such a reorientation of medical practice also might eliminate the need for constant harping on cost containment which, as an end in itself, has great potential for mischief.

Doctor Hunt is coordinator, MSU Medical Humanities Program, and is a member of the Statewide Health Coordinating Committee.



Doctor Rapport is a member of the MSMS Steering Committee on Health Planning, and an MSMS councilor, and is a member of the bed reduction commission of the Genesee-Lapeer-Shiawassee HSA.



Richard L. Rapport, MD, Flint

Legislation dealing with hospital overbedding in Michigan is poorly conceived and will not be effective in its alleged goal to reduce the cost of health care.

The major cost of operating hospital beds is related to employee salaries. Hospitals staff only to occupancy — witness the employee reduction on week-ends and to a greater degree on holidays. Several years ago BCBSM refused to pay for over 1,000 beds which were not being used and discovered they saved nothing.

Savings will be achieved only if hospital beds are reduced to a point where health care is rationed.

Allocating medical care by reducing licensed hospital beds will result in reducing quality medical services; delaying elective hospital admissions (which in some cases might lead to even longer hospital stays in the future); allotting beds to the more affluent; displacing physicians and patients in local community hospitals; disrupting some residency training programs and reducing available

specialists in the future; and decreasing beds reserved for reasonable variations, changes in population and disease mixes, epidemics and catastrophes.

It is impossible to merge hospitals because of differing salary scales, multiple unions, institutional indebtedness, bylaws, retirement plans and institutional loyalty on the part of physicians and employees. Organized medicine would place itself in a paradoxical position were it to approve a plan for bed reduction, a concept which it disavows. The consumer, and not the legislature, should determine how health care is to be rationed.

A surplus of hospital beds today is the direct result of bureaucratic intervention to increase the number of beds in the post World War II period when Hill-Burton was conceived. I can predict in the not too distant future our government will design some fanciful new program to increase the number of beds to compensate for the coming shortage.

Doctor Seifert is a member of the MSMS Steering Committee on Health Planning and of the board of the SW Michigan HSA.



Charles L. Seifert, MD, Battle Creek

Will the bed reduction program save health care dollars? Perhaps. An excess of hospital beds has been built under the sponsorship of the federal government. If delicensing unused beds will prevent the expansion of unnecessary services into the unused beds, that may prevent future waste.

Eliminating duplicated, inefficient services can save money; but not all duplication is inefficient and the number of beds involved may not be the prime factor. Some common services can be provided in a more pleasant atmosphere, more safely, and more cost effectively, in several smaller hospitals than in one large hospital. Time and distance are important factors.

The question is too complex for broad, general statements.

The law is here. To fight the law and to question its effectiveness as written is too little, too late. That battle is past. More importantly, we as physicians should work to protect good quality of care and patterns of care while controlling costs.

Health care is not dollars. It is

not institutions. It is not beds. Health care is provided on a one-to-one relationship by physicians or paramedical personnel to patients. The physician is still in charge, has the closest relationship to the patient and has the ultimate responsibility. Physicians must assume the leadership in directing the final plans of bed reduction in their own service areas.

The health system agency definition of health care providers includes a myriad of people who know nothing of patient's needs, delivery of care or quality of care. These people, along with a myriad of consumers, have the power to sit in committees to hack off beds and disrupt good patterns of care. They need physician guidance.

It is a little late to debate the bed reduction law. Now is the time to direct our energies toward quality implementation of the law.

Robert J. Toteff, MD, Saginaw

If there are excess beds, and many physicians and medical personnel doubt this, there is the potential for over use in order to fill those excess beds. Some argue, with justification, that most beds are occupied because of necessity rather than over utilization.

However, since an excess bed situation has been accepted by our legislators, legislation was passed that the state's excess beds must be delicensed.

The theory behind this is that there will be a cost savings in taking these beds out of circulation. It should be noted that this is basically an untested theory that will be tested in the implementation of the present law.

This is the stage we are at now.

Local areas have been asked to submit a five year plan to get rid of the excess beds in their area. This has been done in an effort to effect "bottom-up planning." If acceptable

plans are not forthcoming, at least as long as the present statute exists, there will be "top-down" planning — first by directing the Statewide Health Coordinating Council to write a plan. If they don't do so, it will fall to the Michigan Department of Public Health. So presently we are about to implement a statute that exists and are doing so by asking local HSAs, who know best about their areas, to write the plan. Whether or not the perceived savings in medical cost will become a reality is yet to be determined. There are many in the medical care delivery systems that doubt the effectiveness of the proposed plan to really accomplish what is desired. Some plans have been submitted and accepted as workable by the local HSAs after many hours of deliberation and compromise. All in all much work is yet to be accomplished and input from physicians is being sought at every level.

Doctor Toteff is a member of the Statewide Health Coordinating Council and of the MSMS Steering Committee on Health Planning.



Myron Wegman, MD, Ann Arbor

Sharp increases in hospital costs are related to unnecessary duplication of hospital facilities, which leads to low occupancy and then over-use to counteract the low occupancy. There we have a classic vicious circle.

In Michigan, use rates are about 1,150 days of hospitalization per 1,000 persons. Yet in some regions of the country, with no demonstrable difference in health problems or status, the figure is as low as 800 days per 1,000 population. Furthermore, in comprehensive prepaid health care organizations (HMOs), both in group practices and associations of individual physicians, the rate varies from 300 to 700.

For the Michigan law, bed need was calculated by a method involving geographic and demographic factors, as well as use and occupancy. The law allows each HSA to develop its own five year plan for achieving the assigned bed reduction.

In southeastern Michigan, a broadly-based commission, including five physicians in clinical practice has spent a year developing a bed reduc-

tion plan for the 76 hospitals in the region.

Chairing this commission has been revealing. During the hours of debate, there has been remarkably little bias displayed, although, naturally, various persons have spoken strongly for their own constituencies.

The plan as a whole is truly a joint effort. It is far from perfect. But one benefit of the five-year period is the opportunity for future revisions annually.

Increased health care costs to provide needed technology and improved health are important and should be funded.

On the other hand, increased costs because of unnecessary duplication of hospital services are wasteful and lead to unfortunate limitations of other needed health services, particularly ambulatory and preventive, not now provided.

I believe this plan is an important step in the right direction and that needed modifications can be achieved as progress is made.

Doctor Wegman is dean emeritus of the University of Michigan School of Public Health and chairman of the bed reduction commission for Comprehensive Health Planning Council of Southeast Michigan.



Doctor Wicks is chief, Special Studies and Analysis Section, Office of Health and Medical Affairs, Michigan Department of Management and Budget.



Elliot K. Wicks, PhD, Lansing

Bed reduction is a tool for inducing change in patterns of medical practice to reduce the use of expensive hospital services. If the bed supply is tight, it is reasonable to expect physicians and hospital administrators to establish priorities to assure beds are occupied only by patients whose medical condition requires hospitalization and to work to develop alternative treatment modes for patients whose needs can be met in other less costly settings.

Without this kind of pressure, practice patterns are unlikely to change because there are few incentives to do so.

How much will bed reduction save?

No one can say with certainty at this point because we do not know which beds will be closed, and because the state of the art simply does not permit precise calculations.

We can be confident, however, that the savings will be substantially greater if the bed closures occur by

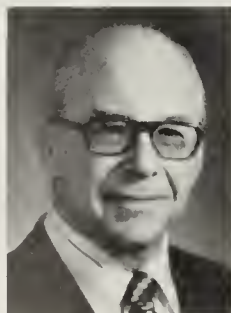
merging or closing whole institutions and by closing entire nursing units rather than piecemeal. Both methods tighten the bed supply, but only the first results in a reduction of fixed overhead costs.

The Governor's Task Force on Hospital Capacity Reduction has estimated the closure of 3,446 beds statewide will produce net savings over 10 years of slightly more than \$800 million. In effect, this means each excess bed costs more than \$23,000 per year.

At the time this estimate was made, none of the bed reduction plans had been prepared. The use of the more recently available information about which beds are to be affected would probably have led to a somewhat lower estimate.

But even if the savings is only half that projected, bed reduction would still be a major contributor to the effort to hold down health care costs in the state.

Doctor Ziel is chief of the Bureau of Health Care Administration, Michigan Department of Public Health, which has ultimate authority in issuance of certificate of need and in writing bed reduction plans.



Hermann A. Ziel, Jr., MD, Lansing

I believe that hospital bed reduction in overbedded subareas will contribute to cost containment and better hospital utilization in the coming years. On the other hand, I am unwilling to predict "savings" at this time since they will depend upon the individual subarea plans, the manner and speed with which the plans are implemented and the costs related to amortizing present indebtedness in hospitals consolidated, closed or otherwise affected by the subarea plan.

My major concern at this time is the many misconceptions related to the bed reduction provisions of the law and the plans. First, there is a failure by many individuals to recognize that the plans cover a five-year period and that the opportunity for annual revisions exist when such revisions are practical and desirable.

Second, there is no direct enforcement of the bed reduction plans. Hospitals affected by the plans are only forced to comply when the hospital makes application for a certificate of need.

Third, there has been some effort to avoid bed reduction planning on a

subarea basis as required in the law, as well as to make the plans hospital specific. Obviously, it will be difficult to review hospital certificate of need applications for consistency with bed reduction plans when the plan is neither subarea nor hospital specific in terms of bed reduction.

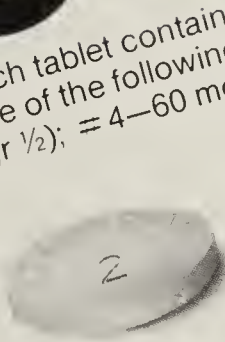
On the other hand, much of what has been accomplished to date is positive, innovative and constructive in terms of achieving the intent of the bed reduction legislation. The Governor's Task Force Report on Hospital Capacity Reduction issued in December 1979 gives constructive guidance to dealing with a number of the problems that will undoubtedly result from the bed reduction efforts.

One final comment is in order. The "appropriateness review" of services required by federal law to be implemented this spring will lend further support to the bed reduction efforts now underway.

To end on a positive note, I believe many individuals and organizations have contributed "mightily" in their dealings with this difficult and desirable program effort.

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HEALTH PLANNING UPDATE

By Dennis Paradis, Director
MSMS Physician/HSA Support Center



Final Report: Governor's Task Force on Hospital Capacity Reduction

When Michigan bed reduction legislation was written, the governor created a task force to investigate the financial and legal considerations that could not be addressed in statute.

These financial and legal considerations are considered so crucial that the bed reduction process is not to be enforced until the report from the Governor's Task Force on Hospital Capacity Reduction is approved.

In December of 1979, the two-volume report was released. It made the following recommendations:

1. That changes in reimbursement policies and establishment of a statewide fund be established to remove real financial barriers to hospital capacity reduction.
2. That a program be established to minimize the number of hospital employees unemployed or underemployed as a result of the capacity reduction program. The program should retain and place such employees in allied health industries or within the hospital industry as attrition creates open positions.
3. That there be a program to minimize the disruptive effects of hospital capacity reduction on individual physicians and their patients.
4. That an amendment to the state antitrust law limit program participants' exposure to antitrust liability and Hospital Capacity Reduction Corporation members and staff be indemnified against litigation.
5. That a special nongovernmental corporation establish a fund to receive monies from the state, federal government and private purchasers of hospital care, such as Blue Cross and Blue Shield of Michigan.
6. That the corporation be granted total jurisdiction over the fund.
7. That the corporation be governed by representatives of providers, purchasers, industry, labor and government.
8. That the corporation be empowered to disburse "up front" money from hospital planning to merge, consolidate or close.

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AVAILABLE ONLY ON PRESCRIPTION

Brief Summary

INDICATION: Tenuate and Tenuate Dospan are indicated in the management of exogenous obesity as a short-term adjunct (a few weeks) in a regimen of weight reduction based on caloric restriction. The limited usefulness of agents of this class should be measured against possible risk factors inherent in their use such as those described below.

CONTRAINDICATIONS: Advanced arteriosclerosis, hyperthyroidism, known hypersensitivity, or idiosyncrasy to the sympathomimetic amines, glaucoma. Agitated states. Patients with a history of drug abuse. During or within 14 days following the administration of monoamine oxidase inhibitors, (hypertensive crises may result).

WARNINGS: If tolerance develops, the recommended dose should not be exceeded in an attempt to increase the effect; rather, the drug should be discontinued. Tenuate may impair the ability of the patient to engage in potentially hazardous activities such as operating machinery or driving a motor vehicle; the patient should therefore be cautioned accordingly. **Drug Dependence:** Tenuate has some chemical and pharmacologic similarities to the amphetamines and other related stimulant drugs that have been extensively abused. There have been reports of subjects becoming psychologically dependent on diethylpropion. The possibility of abuse should be kept in mind when evaluating the desirability of including a drug as part of a weight reduction program. Abuse of amphetamines and related drugs may be associated with varying degrees of psychologic dependence and social dysfunction which, in the case of certain drugs, may be severe. There are reports of patients who have increased the dosage to many times that recommended. Abrupt cessation following prolonged high dosage administration results in extreme fatigue and mental depression; changes are also noted on the sleep EEG. Manifestations of chronic intoxication with anorectic drugs include severe dermatoses, marked insomnia, irritability, hyperactivity, and personality changes. The most severe manifestation of chronic intoxications is psychosis, often clinically indistinguishable from schizophrenia. **Use in Pregnancy:** Although rat and human reproductive studies have not indicated adverse effects, the use of Tenuate by women who are pregnant or may become pregnant requires that the potential benefits be weighed against the potential risks. **Use in Children:** Tenuate is not recommended for use in children under 12 years of age.

PRECAUTIONS: Caution is to be exercised in prescribing Tenuate for patients with hypertension or with symptomatic cardiovascular disease, including arrhythmias. Tenuate should not be administered to patients with severe hypertension. Insulin requirements in diabetes mellitus may be altered in association with the use of Tenuate and the concomitant dietary regimen. Tenuate may decrease the hypotensive effect of guanethidine. The least amount feasible should be prescribed or dispensed at one time in order to minimize the possibility of overdosage. Reports suggest that Tenuate may increase convulsions in some epileptics. Therefore, epileptics receiving Tenuate should be carefully monitored. Titration of dose or discontinuance of Tenuate may be necessary.

ADVERSE REACTIONS: *Cardiovascular:* Palpitation, tachycardia, elevation of blood pressure, precordial pain, arrhythmia. One published report described T-wave changes in the ECG of a healthy young male after ingestion of diethylpropion hydrochloride. *Central Nervous System:* Overstimulation, nervousness, restlessness, dizziness, jitteriness, insomnia, anxiety, euphoria, depression, dysphoria, tremor, dyskinesia, mydriasis, drowsiness, malaise, headache; rarely psychotic episodes at recommended doses. In a few epileptics an increase in convulsive episodes has been reported. *Gastrointestinal:* Dryness of the mouth, unpleasant taste, nausea, vomiting, abdominal discomfort, diarrhea, constipation, other gastrointestinal disturbances. *Allergic:* Urticaria, rash, ecchymosis, erythema. *Endocrine:* Impotence, changes in libido, gynecomastia, menstrual upset. *Hematopoietic System:* Bone marrow depression, agranulocytosis, leukopenia. *Miscellaneous:* A variety of miscellaneous adverse reactions has been reported by physicians. These include complaints such as dyspnea, hair loss, muscle pain, dysuria, increased sweating, and polyuria.

DOSE AND ADMINISTRATION: Tenuate (diethylpropion hydrochloride): One 25 mg. tablet three times daily, one hour before meals, and in mid-evening if desired to overcome night hunger. Tenuate Dospan (diethylpropion hydrochloride) controlled-release: One 75 mg. tablet daily, swallowed whole, in mid-morning. Tenuate is not recommended for use in children under 12 years of age.

OVERDOSAGE: Manifestations of acute overdosage include restlessness, tremor, hyperreflexia, rapid respiration, confusion, assaultiveness, hallucinations, panic states. Fatigue and depression usually follow the central stimulation. Cardiovascular effects include arrhythmias, hypertension or hypotension and circulatory collapse. Gastrointestinal symptoms include nausea, vomiting, diarrhea, and abdominal cramps. Overdose of pharmacologically similar compounds has resulted in fatal poisoning, usually terminating in convulsions and coma. Management of acute Tenuate intoxication is largely symptomatic and includes lavage and sedation with a barbiturate. Experience with hemodialysis or peritoneal dialysis is inadequate to permit recommendation in this regard. Intravenous phentolamine (Regitine®) has been suggested on pharmacologic grounds for possible acute, severe hypertension, if this complicates Tenuate overdosage.

Product Information as of April, 1976

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References: 1. Citations available on request from Medical Research Department, MERRELL-NATIONAL LABORATORIES, Cincinnati, Ohio 45215. 2. Hoekenga, M.T., O'Dillon [Oillon], R.H., and Leyland, H.M. A comprehensive review of diethylpropion hydrochloride. In: *Central Mechanisms of Anorectic Drugs*, S. Garattini and R. Samanin, Ed., New York, Raven Press, 1978, pp. 391-404.

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**Overweight may not always be simple...
complications can develop.***

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A useful short-term adjunct in an indicated weight loss program.

Overweight patients in certain diagnostic categories often require strict appetite control and a successful program of weight reduction may tend to diminish the incidence or severity of the complications in some patients. Diethylpropion hydrochloride has been reported useful in such patients and while it is not suggested that Tenuate itself in any way reduces the complications of overweight, it may have a useful place as a short-term adjunct in a prescribed dietary regimen. **Tenuate should not be administered to patients with severe hypertension; see additional Warnings and Precautions on the opposite page.**

In uncomplicated overweight.

Many patients, on the other hand, present with excess fat but no disease. While this condition is often termed uncomplicated obesity, complications of both a social and a psychologic nature may be distressingly real for the patients. In these cases, a short-term regimen of Tenuate can help reinforce your dietary counsel during the important early weeks of an indicated weight loss program.

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The anorectic effectiveness of diethylpropion hydrochloride is well documented. No less than 16 separate double-blind, placebo-controlled studies attest to its usefulness in daily practice.¹ And the unique chemistry of Tenuate provides "...anorectic potency with minimal overt central nervous system or cardiovascular stimulation."² Compared with the amphetamines, diethylpropion has minimal potential for abuse.

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*Studies have shown that obesity is associated with an increased incidence of hypertension, symptomatic heart disease, adult-onset diabetes, and other diseases.

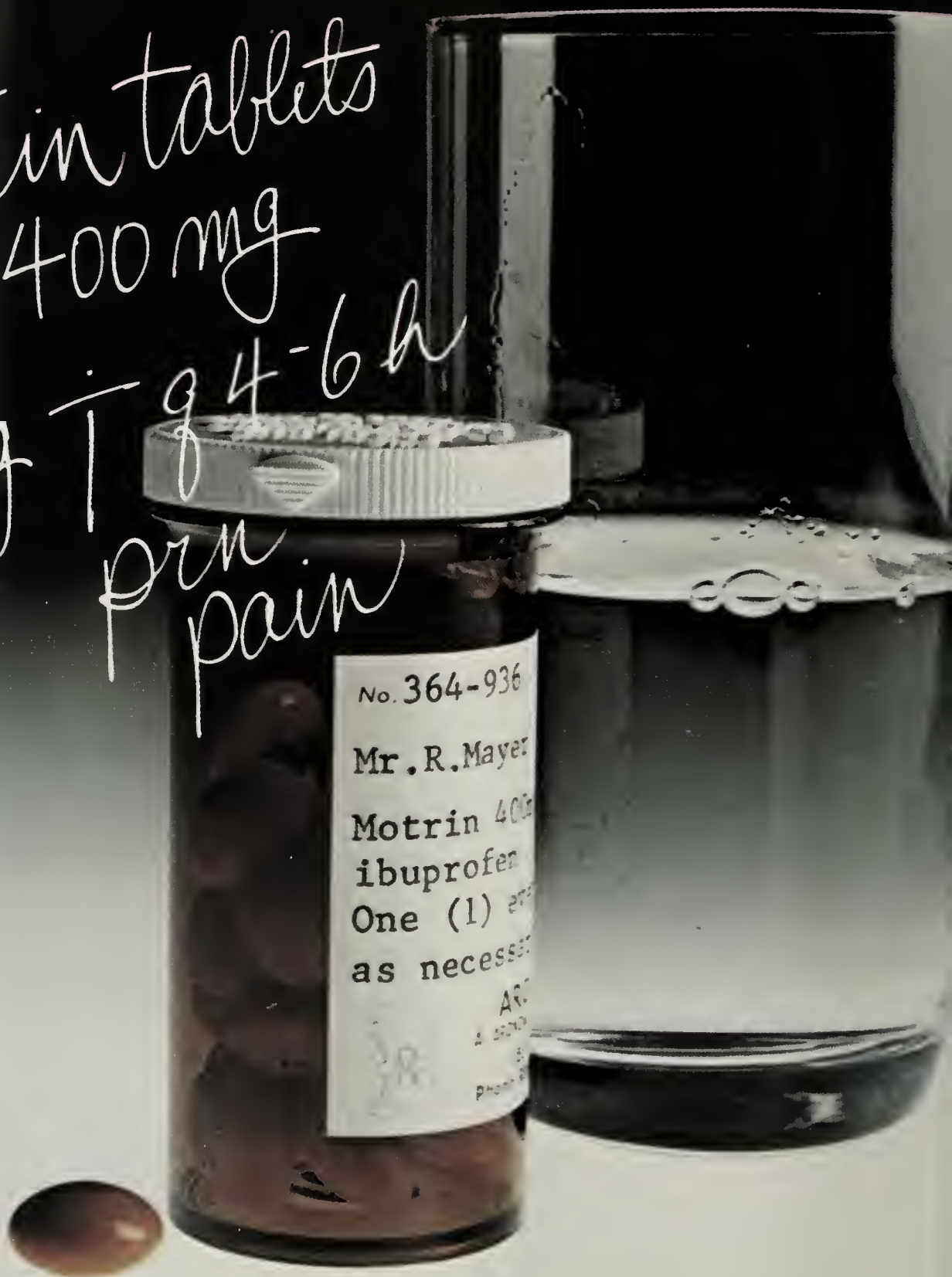
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For prescribing information see opposite page.

A well-tolerated, nonnarcotic prescription for pain

Motrin tablets
400 mg
Sig T q 4-6 h
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Motrin[®] now proved an effective analgesic for mild to moderate pain

Motrin 400 mg provided greater relief of pain than did propoxyphene 65 mg in controlled clinical pain studies.

Time after drug administration (hour)		.5	1	2	3	4
Mean relief-of-pain scores* (No. patients reporting)	Motrin 400 mg ibuprofen	.89 (108)	1.25 (108)	1.36 (108)	1.28 (107)	1.19 (106)
	Darvon 65 mg propoxyphene	.66 (100)	.99 (99)	1.13 (96)	.99 (96)	.80 (96)
Statistical significance		p<0.02	p<0.01	p<0.05	p<0.02	p<0.002

*0 = No relief 1 = Partial relief 2 = Complete relief

Data on file at The Upjohn Company

Motrin demonstrated statistically significant greater relief of pain than did Darvon at all time intervals.

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- Not a narcotic • Not addictive • Not habit forming
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Motrin[®] Tablets (ibuprofen, Upjohn)

Indications and Usage: Treatment of signs and symptoms of rheumatoid arthritis and osteoarthritis during acute flares and in long-term management. Safety and efficacy have not been established in Functional Class IV rheumatoid arthritis.

Relief of mild to moderate pain.

Contraindications: Individuals hypersensitive to it, or with the syndrome of nasal polyps, angioedema and bronchospastic reactivity to aspirin or other nonsteroidal anti-inflammatory agents (see WARNINGS).

Warnings: Anaphylactoid reactions have occurred in patients with aspirin hypersensitivity (see CONTRAINDICATIONS).

Peptic ulceration and gastrointestinal bleeding, sometimes severe, have been reported. Ulceration, perforation, and bleeding may end fatally. An association has not been established. Motrin should be given under close supervision to patients with a history of upper gastrointestinal tract disease, only after consulting ADVERSE REACTIONS.

In patients with active peptic ulcer and active rheumatoid arthritis, nonulcerogenic drugs, such as gold, should be tried. If Motrin must be given, the patient should be under close supervision for signs of ulcer perforation or gastrointestinal bleeding.

Precautions: Blurred and/or diminished vision, scotomata, and/or changes in color vision have been reported. If these develop, discontinue Motrin and the patient should have an ophthalmologic examination, including central visual fields.

Fluid retention and edema have been associated with Motrin; use with caution in patients with a history of cardiac decompensation.

Motrin can inhibit platelet aggregation and prolong bleeding time. Use with caution in persons with intrinsic coagulation defects and those on anticoagulant therapy.

Patients should report signs or symptoms of gastrointestinal ulceration or bleeding, blurred vision or other eye symptoms, skin rash, weight gain, or edema.

To avoid exacerbation of disease or adrenal insufficiency, patients on prolonged corticosteroid therapy should have therapy tapered slowly when Motrin is added.

Drug interactions. *Aspirin:* used concomitantly may decrease Motrin blood levels. *Coumarin:* Bleeding has been reported in patients taking Motrin and coumarin.

Pregnancy and nursing mothers: Motrin should not be taken during pregnancy or by nursing mothers.

Adverse Reactions

Incidence greater than 1%

Gastrointestinal: The most frequent type of adverse reaction occurring with Motrin is gastrointestinal (4% to 16%). This includes nausea,* epigastric pain,* heartburn,* diarrhea, abdominal distress, nausea and vomiting, indigestion, constipation, abdominal cramps or pain, fullness of the GI tract (bloating and flatulence). **Central Nervous System:** Dizziness,* headache, nervousness. **Dermatologic:** Rash* (including maculopapular type), pruritus. **Special Senses:** Tinnitus. **Metabolic:** Decreased appetite, edema, fluid retention. Fluid retention generally responds promptly to drug discontinuation (see PRECAUTIONS).

*Incidence 3% to 9%.

Incidence less than 1 in 100

Gastrointestinal: Upper GI ulcer with bleeding and/or perforation, hemorrhage, melena. **Central Nervous System:** Depression, insomnia. **Dermatologic:** Vesiculobullous eruptions, urticaria, erythema multiforme. **Cardiovascular:** Congestive heart failure in patients with marginal cardiac function, elevated blood pressure. **Special Senses:** Amblyopia (see PRECAUTIONS). **Hematologic:** Leukopenia, decreased hemoglobin and hematocrit.

Causal relationship unknown

Gastrointestinal: Hepatitis, jaundice, abnormal liver function. **Central Nervous System:** Paresthesias, hallucinations, dream abnormalities. **Dermatologic:** Alopecia, Stevens-Johnson syndrome. **Special Senses:** Conjunctivitis, diplopia, optic neuritis. **Hematologic:** Hemolytic anemia, thrombocytopenia, granulocytopenia, bleeding episodes. **Allergic:** Fever, serum sickness, lupus erythematosus syndrome. **Endocrine:** Gynecomastia, hypoglycemia. **Cardiovascular:** Arrhythmias. **Renal:** Decreased creatinine clearance, polyuria, azotemia.

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MED B-4-S

Doctor Hayes 'between rock, hard place' most of years with the Blues

By Shelton Reece, special to Michigan Medicine



Doctor Hayes, center, during his days with BCBSM.

Outgoing Blue Cross Blue Shield of Michigan Vice President Louis F. Hayes, MD, says he believes MSMS was coming to the point recently where it felt some of its goals and objectives were close to those of the Blues and that maybe the two groups should sit down and talk.

But then "the FTC reared its head and made charges based on fallacies they are eagerly trying to prove to be true.

"I don't say none of the FTC charges (in its complaint of illegal MSMS activities with the Blues) has any validity," says Doctor Hayes. "But there's really nothing that couldn't have been solved by all parties working on some problems and taking action."

As it is now, he says, "this thing" probably will drag on for three to five years until no one really much cares what the outcome may be.

"The FTC will lose some of its steam, and learn this endeavor is too costly."

Not happy

Doctor Hayes, who retired March 1 after 12 years as BCBSM vice president for professional affairs, says he feels privileged to have lived during this time, but is "not at all happy with what has happened in every instance."

When he came into the job, he said, he was naive and had high hopes he could develop a good working rela-

tionship and close understanding between MSMS and the Blues.

"I really thought we could develop health care coverage that would provide for all legitimate needs of subscribers, and each doctor would use it judiciously," he says.

"I thought the whole system would be so satisfactory to patients, physicians, hospitals, the automobile companies, unions, and other customers that no one would be upset with anyone else.

"Obviously, I was very wrong, as we all know," he says.

The years he has served as BCBSM vice president, he says, were a time when MSMS and the Blues "could have made their greatest progress in cementing a meaningful relationship. We were plowing unknown ground with Medicare and Medicaid, and the Blues were developing new payment methods and expanded benefits."

But MSMS leaders with outdated ideas, he charges, built an anti-Blues attitude.

"They were fine physicians and served their society well," he says, "but, regrettably, they had economic blinders.

"They believed third-party payors themselves were anathema, that third parties interfered greatly with that holy, and somewhat overrated, relationship between patients and their doctors.

"There were just a few of them,

but they were quite vocal."

Physician input

The anti-Blues attitude did not take long to develop to the point where in 1971 there occurred the "divorce," he recalls, which "essentially caused physicians to abdicate their right to nominate physicians to the Blues' Board of Directors.

"The result of this was that physicians no longer spoke with authority, or any right, in areas concerning the Blues.

"I feel this is extremely unfortunate," he says. "If we could have worked together and discussed our differences and mutual problems, the health care situation could have been better in this state."

BCBSM actually had great need for input from doctors and the profession probably could have benefited from advising BCBSM in several areas, particularly peer review, says Doctor Hayes. But there was no cooperation, he says, so the Blues devised ways of trying to deal with various problems.

"Of course we acted unilaterally, as MSMS charges," he says. "There was no way to act bilaterally."

Doctor Hayes says he believes the pendulum had slowly begun to swing the other way recently, when the FTC entered the picture.

"After the smoke blows away, it probably will take five to 10 years before all parties in this state will truly

LOUIS HAYES/continued

realize they do have some common goals," he says, "and that they can trust each other enough to at least talk meaningfully to each other without harming anyone.

"Maybe then some real progress can be made."

Changes needed

Doctor Hayes, who is beginning a new career in South Carolina with a consumer education group, suggests many things must change, "as we are learning from the era of health planning councils." Those councils, he observes, are becoming "the new enemy of medicine as a whole and soon may replace the Blues in that unwanted role."

Physicians must recognize the forces of change and adapt to those forces, he says.

"I truly appreciate . . . good relationships with most physicians throughout the state."

"It is important for us to understand we alone do not have a solemn and God-given right to make every decision necessary in the large arena of health care," he says. "There are others who have a real interest, which is honest and genuine, in some of those decisions. And those people have a right to participate in decisions."

Physicians will have to recognize the economic impact of some of their decisions, he continues.

"Some day we will have to," he says, "when we realize that every new physician who starts practice adds about \$250,000 per year to overall health care costs.

"There will come a time when we all will understand we just can't afford to have more and more people doing more and more things for more and more patients. Physicians should get involved in health planning.

"Considering the huge impact of health care costs on the country's overall economy, we probably will have to ask ourselves soon if we should shift gears and turn from treating illnesses to trying to prevent them.

"Also, we must ask ourselves if the patient can do more for him/herself, thereby being less dependent upon physicians?"

Physicians need not worry their profession will become outdated, or their incomes curtailed, he soothes. There will always be enough new people demanding medical care and society always has paid its physicians well.

"But as physicians, we must accept and plan for change and help get things done that are in the interest of society as well as the profession."

Forward, backward

Doctor Hayes plans to begin work soon with a consumer education group. He was an MSMS councilor for six years, vice speaker of the MSMS House of Delegates for four years and a delegate to the House for 15 years.

Doctor Hayes is extremely reluctant to talk about any successes achieved during his years at Blue Cross Blue Shield of Michigan. He says there was no progress that was his entirely; that he always acted, and achieved, as part of a team.

When pressed, he will admit there are certain advancements made during his tenure of which he is proud. These include the Blues broadened reimbursement systems, Blue Cross and Blue Shield of Michigan consolidation, the newly developed Network Program, the investigation into the question of collusion between some physicians and independent laboratories, the construction of the handsome Blue Cross Blue Shield building, and — just possibly — because of the work he and his excellent field staff did, the "physicians' revolution against the Blues" was not as great as it could have been.

"I was between a rock and a hard place most of the time at the Blues," he states. "One of the things that was the most help to me during those years was that somehow I could maintain good personal relationships with most physicians throughout the state.

"No matter how bitterly opposed we might have been to each other on the issues, somehow they always were able to separate the person from the issues or corporation that I represented.

"I truly appreciate that."

'Bill of rights' guarantees patients access to records

Article provided by the attorney general's office.

Do patients have the right to obtain medical records from their doctor's or hospital's files?

This question is raised more frequently as the cost of health care skyrockets and patients become more aware of their rights.

Under Michigan law, patients of hospitals, institutions and private physicians have the right to see and obtain copies of their medical records.

The legislature included a "Patient Bill of Rights" in Michigan's new Public Health Code which covers nursing homes, homes for the elderly and similar facilities.

This law allows patients to inspect their medical records or receive copies for a reasonable fee.

The law enables physicians to use their discretion about what forms to use, information to be recorded and how long the records are to be kept.

For mental patients, the law is a little different.

It allows the doctor or hospital to withhold the record if such information would be detrimental to the patients or others involved.

To obtain access to medical records, three steps are advisory.

First, the patient must allow enough time after making the request. The physician or health care facility must have sufficient time to assemble and copy the records.

Second, the patient must be prepared to pay a reasonable fee to cover the cost of assembling and reproducing the records. X-rays require special equipment and extra cost.

Third, if the patient wants to look at the records — without getting copies — he or she must make arrangements in advance, to review them during normal business hours.

A doctor's refusal to provide medical records is usually a private matter to be discussed on an individual basis or with the help of a private attorney.

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before treatment. If an allergic reaction occurs, discontinue the drug and treat with the usual agents (e.g., epinephrine or other pressor amines, antihistamines, or corticosteroids).

Precautions: Use with caution in individuals with histories of significant allergies and/or asthma. Do not rely on oral administration in patients with severe illness, nausea, vomiting, gastric dilatation, cardiospasm, or intestinal hypermotility. Occasional patients will not absorb therapeutic amounts given orally. In streptococcal infections, treat until the organism is eliminated (minimum of ten days). With prolonged use, nonsusceptible organisms, including fungi, may overgrow; treat superinfection appropriately.

Adverse Reactions: Hypersensitivity, including fatal anaphylaxis. Nausea, vomiting, epigastric distress, diarrhea, and black, hairy tongue. Skin eruptions, urticaria, reactions resembling serum sickness (including chills, edema, arthralgia, prostration), laryngeal edema, fever, and eosinophilia. Infrequent hemolytic anemia, leukopenia, thrombocytopenia, neuropathy, and nephropathy, usually with high doses of parenteral penicillin.

[102175]

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Blues president answers charges inspiring call for BCBSM reform

By Willah Weddon, special to Michigan Medicine



Mister McCabe

"The unions think doctors control us. Doctors think the unions do. I think we shouldn't be controlled by anyone . . . or else go out of business," John C. McCabe, president of Blue Cross and Blue Shield of Michigan (BCBSM), states flatly.

McCabe contends over-regulation has impaired the ability of BCBSM in past years to compete with commercial health insurance companies. He says further regulation by the state may cripple it beyond repair. "I'm not afraid of competition, I'm afraid of unequal treatment," he emphasizes.

McCabe was in Lansing to address a meeting of professional journalists (Sigma Delta Chi) recently, and dealt primarily with provisions in House Bill 4555, designed to reorganize BSBCM. He gave the impression of a man fighting for the life of his company as he methodically and forcefully presented the case in defense of the "Blues."

Responding to charges in a legislative analysis referring to the "apparent problem" requiring reorganization of BCBSM, McCabe countered:

Unduly secretive? "Present regulations forbid any secrecy and there is none." BCBSM is audited every three years by the state insurance bureau, has an average of 37 audits annually by various agencies and the state insurance commissioner has the right to see any BCBSM documents at any time.

Arrogant? "If we are arrogant, it's because we've persisted in thinking some things are inappropriate, such as undue regulatory activities over the past seven to eight years.

And the Supreme Court has upheld us in eight out of nine issues."

Unresponsive to the aged? "We never proposed cutting off our subscribers after they went on Medicaid, as the insurance commissioner alleged." BCBSM suggests commercial insurance companies should continue to provide coverage for retired persons.

McCabe faulted the Attorney General's office for not enforcing the "Cooper Bill," which was passed into law last year and requires commercial insurance companies to offer some continuing protection to retired workers.

Reserve funds too big? He insists a reserve fund is necessary to provide stable rates. "You have to have adequate reserves to protect against unforeseen expenses. 'Narrow corridor' reserve limitations would lead to triggering rate adjustments as often as two or three times a year."

Not vigorous in cost-containment? "We now have 84 separate, identifiable programs affecting emergency rooms, doctor's fees, hospital reimbursements, blood tests, X-rays, length of hospital stays, over-bedding, use of new technology. . . . In 1978 we saved \$466 million compared to what would have been spent by commercial insurance companies that by and large pay what is charged and submitted on the claim form. The increase in the health care cost index in southeastern Michigan in 1978 was lower than the increase in the consumer's price index. That didn't just happen."

McCabe recognizes that BCBSM, although non-profit, must compete as a business against other businesses.

He considers the primary purpose of BCBSM to be "a health care prepayment system."

He claims the State attorney general's office is sitting on an opinion regarding the Blues' right to originate an Insurance Agency which could offer life, accident, disability or dismemberment insurance so they could compete with other companies offering "package" insurance programs.

50,000 of their 5.4 million subscribers were lost in 1978 to insurance companies offering package programs, according to BCBSM statistics, he says.

Profits from such an agency, should one be established, would be channeled back to help offset losses incurred by the health insurance policies as in commercial health insurance companies.

When it comes to the tax-exempt status the Blues enjoy, McCabe thinks it could be the worst thing that's happened to them.

"It is used as a pretext for every form of harassment that various people can direct at us. If we lost that exemption, we'd still retain our market share. Our success is not based on that so-called privilege, it's based on the kind of service and benefits we provide and on a variety of things we do that individual customers use to measure us against the competition."

"We have been working with physicians in the area of cost containment and medical access to medical care," McCabe said.

BCBSM has individual contracts with 12,000 physicians and 260 hospitals. He said, "There has to be some balance between what we want and what they want. We cannot function as some would want us to function, just by saying 'This is the way it is.' It won't work. It's a matter of negotiation."

During a question and answer session, Cynthia Kyle, Associated Press reporter, asked McCabe who or what was responsible for the present criticism and proposed legislation, if BCBSM was everything he said it was.

"To a certain extent it has to do with visibility," he said. "We are a very big, visible blue whale and draw public attention. As a result, it becomes something of a political issue."

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Michigan ophthalmologists use media to preserve identity

By Philip C. Hessburg, MD, Grosse Pointe Park
and Justin L. Moran, East Lansing

If you can read these words easily, it means that your eyesight is probably good—maybe even 20/20. But it doesn't mean that your eyes are healthy. Only a Medical Doctor or a Doctor of Osteopathy who is an Ophthalmologist can tell you that. Because only an Ophthalmologist can diagnose and treat all eye disorders—from poor vision to serious brain diseases. Be sure your benefit program permits you to choose eye care by an Ophthalmologist. ☐ Then see one, and see.



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Medical Eye Services

OF MICHIGAN, INC.

A non-profit advisor to eye care programs.

1010 Antietam Road, Detroit, MI 48207 (313) 962-2394

This MESOM ad appeared in Michigan Medicine.

This is the second of a two-part series describing Michigan ophthalmologists' aggressive efforts to fight off the encroachments of optometry. The first part, published in the February issue of *Michigan Medicine*, provided the background.

Optometrists, seeking to become "the family physician of the eye," have worked 25 years for legislation to allow them to use diagnostic pharmaceutical agents and prescribe medication. In many states, though not in Michigan, they now have this right.

Negotiated vision care benefit programs favoring optometrists are another major encroachment, according to the first installment of this series. The greatest challenge, however, comes from major eyeglass manufacturing corporations moving into the examination field.

Now, what ophthalmologists are doing about all this:

The most obvious program mounted by Michigan ophthalmologists to resist optometric encroachment on their practices is the ophthalmologists' public information and communications program. This program, which is funded by the voluntary contributions of over 60 percent of the practicing ophthalmologists in the state, uses paid advertising to create a demand for ophthalmological eye examinations.

Michigan ophthalmologists have formed Medical Eye Services of Michigan, Inc., as the specialty's marketing arm. MESOM's principal functions are to advise vision care plans, to provide panels of ophthalmologists for third-party plans and to promote the use of ophthalmological services.

Before developing the program, MESOM commissioned a major market research study to identify problem areas in mass marketing the services of ophthalmologists.

The study showed the public has no idea of the difference between an ophthalmologist and the optometrist. In fact, the study showed the public thought the relationship to be the same as that between doctors of medicine and doctors of osteopathy — e.g., they have substantially the same training and do substantially the same thing.

Moreover, the study indicated the public perceives vision care in a basically mechanical rather than medical context. The public reasons: when vision fails, one needs eyeglasses to restore good vision. To obtain these appliances, one must see the mechanic (ophthalmologist or optometrist) who purveys them.

MESOM engaged an advertising agency and appointed a Public Information and Communications Council composed of physicians participating in MESOM vision care plans to oversee a public education program.

The council identified two audiences with which it must communicate: "leaders of thought," business executives and union officers who

(continued on page 130)



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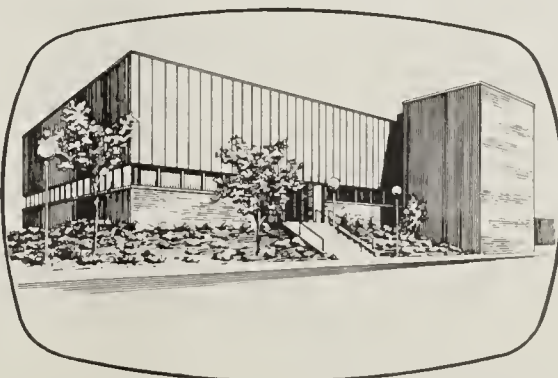
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One of MESOM's clarifying advertisements.

would be involved in negotiating for or granting vision care benefits, and the mass market of patients seeking routine eye examinations.

To reach "thoughtleaders," MESOM created two advertisements for publication in weekly news-magazines (*Time*, *Newsweek* and *U.S. News and World Report*).

The first of these advertisements creates awareness of the differences between an ophthalmologist and an optometrist. The headline reads, "Only an ophthalmologist can diagnose and treat these four common eye diseases." The ad copy makes a distinction between the complete medical eye examination provided by an ophthalmologist and the vision examination provided by an optometrist. The copy also promotes group vision care benefits which permit the choice of an ophthalmological examination. Four color photographs are used to insure high levels of readership.

Doctor Hessburg is president of the Michigan Ophthalmological Society, and Mr. Moran is director, MOS public information and communications.

The Council created a second advertisement for the newsmagazine audience. This advertisement draws a distinction between good eyesight and "healthy" eyes. It also advises readers to be sure their benefit programs permit them to choose eye care by an ophthalmologist.

To insure these two advertisements were seen and read by union leaders, the Council mailed reprints to all 2,800 elected union officials in Michigan.

The Council had to develop a second campaign to reach the "mass" audience. Television is the best medium to reach this group. However, television production and time charges are too expensive. Therefore, the MESOM Public Information and Communications Council decided to advertise in the television program guides of major Michigan Sunday newspapers and in *TV Guide* magazine.

MESOM created two straightforward advertisements for use in these publications. The first has a headline reading, "When an MD or Osteopath prescribes your glasses, you get the finest eye care possible." The second advertisement outlines the capabilities

of ophthalmologists and optometrists and asks, "Which would you rather see?"

The copy in both advertisements impresses upon readers the importance of seeking a medical eye examination from a physician rather than a simple vision check from an optometrist.

Both advertisements contain a toll-free telephone number prospective patients can call from anywhere in the state for the names of ophthalmologists practicing nearby.

The main thrust of the program is at the "mass" market. Full-page advertisements will be published in the Sunday television guides of the two Detroit papers, the Flint, Lansing and Grand Rapids papers and the *Upper Peninsula Sunday Times* and in *TV Guide's* Michigan edition each week for an indefinite period of time.

It is still too early to measure the results of the advertising program. However, new market research is planned for late spring or early summer. This study will provide data to redirect the program if that is necessary. In the meantime, the volume of telephone calls received on the MESOM toll-free line will be recorded and used to compare the effectiveness of various "mass" market advertisements.

Word of the marketing effort undertaken by Michigan ophthalmologists has begun to spread to other states. Philip C. Hessburg, MD, president of the Michigan Ophthalmological Society, was invited to report on the Michigan program at the recent meeting of the American Academy of Ophthalmology. He also spoke at a recent meeting of PEN (Physician's Education Network), an organization of ophthalmologists fighting optometric drug bills in other states. At least a dozen other state ophthalmological societies have inquired about the program and have indicated interest in purchasing the right to use the Michigan advertisements.

Ophthalmology's fight to survive has just begun in Michigan and has reached only the discussion stage in most other states. At this time, the outcome is still very much in doubt. However, if Michigan's ophthalmologists do not win, it will not be because they did not try with every resource at their disposal.

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Attn: Marketing Services

PEDIATRIC HYPERTENSION — GUIDELINES FOR SCREENING

Risk

- Factors:**
1. Positive family history
 2. History of diabetes mellitus
 3. Obese persons

Diagnostic

Criteria:

1. Stock five widths of cuff sizes.
2. Assure bladder encircles arm without overlapping. This will require several bladder lengths for each cuff width.
3. Use fourth phase Korotkoff sound (muffling) for diastolic pressure.
4. Use multiple determinations especially if blood pressure exceeds 95th percentile. See reference charts.* DO NOT label as hypertensive on sporadic elevation. Investigate thoroughly if sustained blood pressure is abnormal.
5. Exclude secondary causes - renal, cardiovascular, endocrine, CNS, collagen disease.

Who to

Screen:

Every child after age 3

When to

Screen:

Every time you see patients or at least annually.

Treatment:

1. Dietary - weight control, salt intake control.
2. Medical - requires serious consideration of adverse effects of long term treatment vs. anticipated gains.

* - PEDIATRICS 59, No. 5, Part 2:803; Figure 1 and 2, 1977; shown on the reverse side of this card.

These guidelines along with those relative to atherosclerotic cardiovascular disease in the young have been developed by the Heart Disease in the Young Committee, Michigan Heart Association, and approved by the Board of Trustees on November 16, 1977.

MICHIGAN HEART ASSOCIATION, 16310 West 12 Mile Road, Southfield, Michigan 48076

Member: United Way of Michigan



Affiliate: American Heart Association

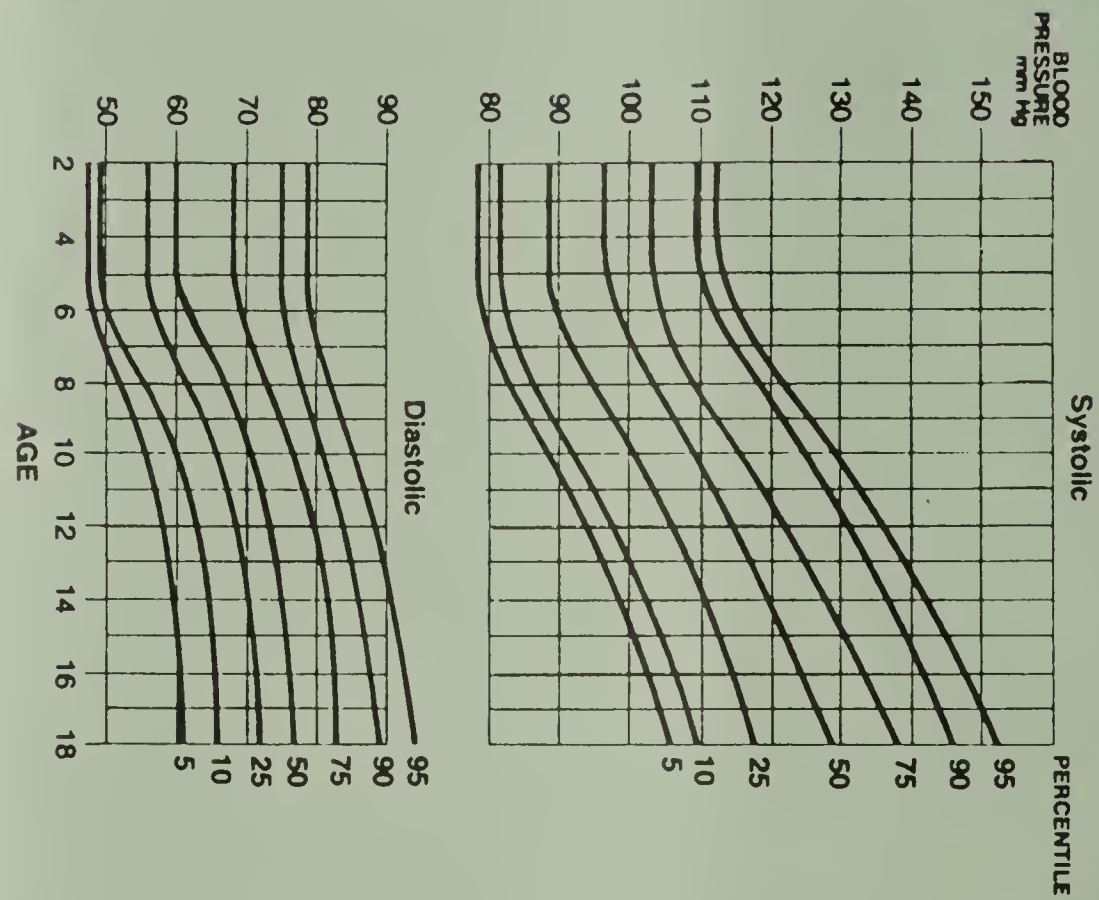


Fig. 1. Percentiles of blood pressure measurement in boys (right arm, seated).

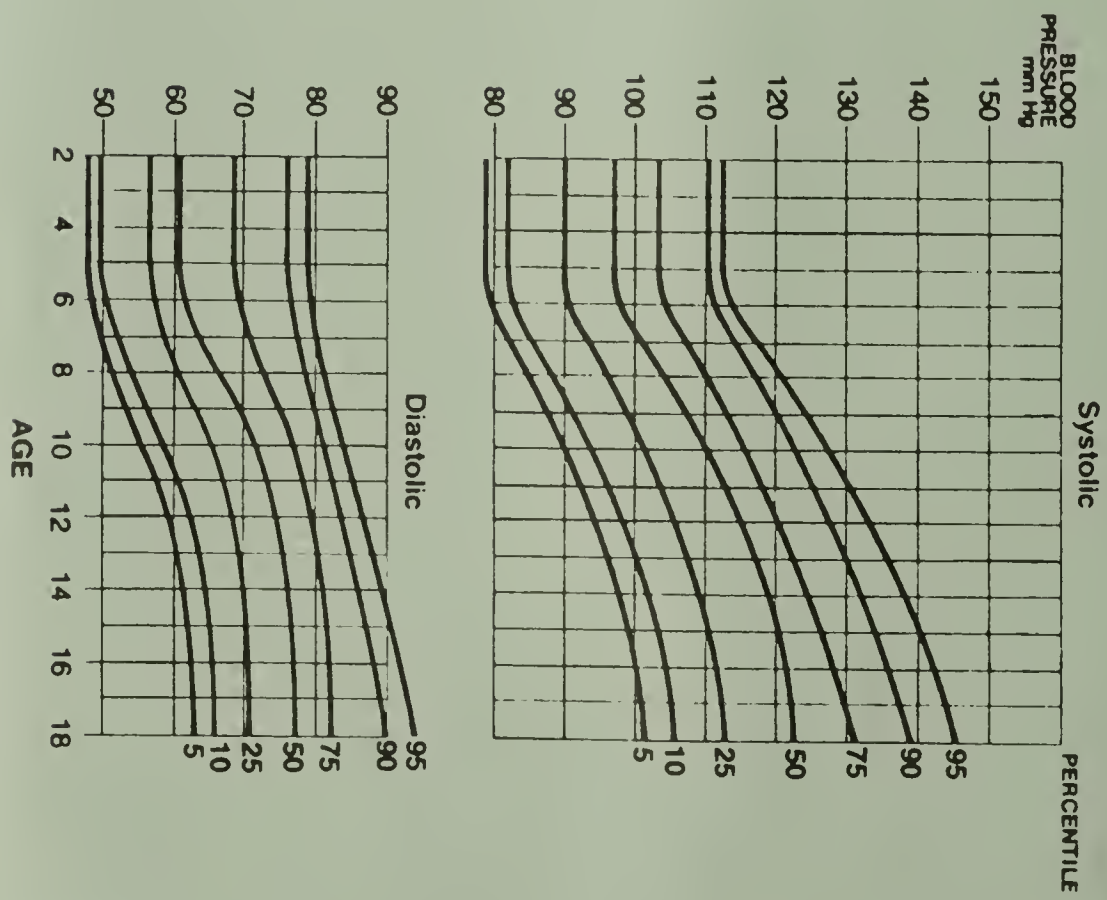


Fig. 2. Percentiles of blood pressure measurement in girls (right arm, seated).

81-051B
5-78-6M

MICS-1210

ATHEROSCLEROTIC CARDIOVASCULAR DISEASE IN THE YOUNG

GUIDELINES FOR SCREENING

Risk Factors:	1. Definite	2. Suspected	3. Controversial
	a. Hypercholesterolemia b. Cigarette smoking c. Hypertension	a. Diabetes mellitus b. Hypertriglyceridemia	a. Obesity b. Physical inactivity (sedentary life style)
Diagnostic Criteria	1. Specimen drawn after overnight twelve hour fast.		
	2. Measure serum cholesterol and triglycerides (2 - 3 samples). Note serum characteristics on standing overnight at 4 degrees C. (Normal values: Lauer: JOURNAL OF PEDIATRICS, 86:697 - 706, 1975*; Frerichs: CIRCULATION 54:302-318, 1976)		
Hyperlipidemia:	3. Exclude secondary causes:		
	a. Nephrotic syndrome b. Hypothyroidism c. Glycogen storage disease d. Juvenile diabetes mellitus e. Uremia f. Obstructive liver disease g. Acute intermittent porphyria		
Who to Screen:	1. All first degree relatives of a parent with a history of myocardial infarction occurring age fifty or less.		
	2. Family history of hyperlipidemia.		
	3. All hypertensives		
	4. Smokers		
	5. Obese (greater than 95th percentile for age and height)		
	6. All diabetics		
When to Screen:	1. Age three in general population.		
	2. Earlier in patient with a family history of myocardial infarction or hyperlipidemia.		
Treatment Opportunities:	1. Dietary - aim to reduce cholesterol 15% or more.		
	2. Medical - maintenance of fitness, avoidance of obesity and smoking recommended. - long term medical treatment in pediatric age group is currently research effort only.		

* - J OF PED, 86:698, figure 1 and 86:700, figure 2, shown on reverse side of this card.

These guidelines along with those relative to pediatric hypertension have been developed by the Heart Disease in the Young Committee, Michigan Heart Association, and approved by the Board of Trustees on November 16, 1977.

MICHIGAN HEART ASSOCIATION, 16310 West 12 Mile Road, Southfield, Michigan 48076
Member: United Way of Michigan



Affiliate: American Heart Association

From Lauer, Ronald M., Connor, William E., Leaverton, Paul E., Reiter, Mary Ann and Clarke, William R.: Coronary heart disease risk factors in school children: The Muscatine Study, JOURNAL OF PEDIATRICS, 86: 697-706, 1975. (By permission of the primary author and the publisher.)

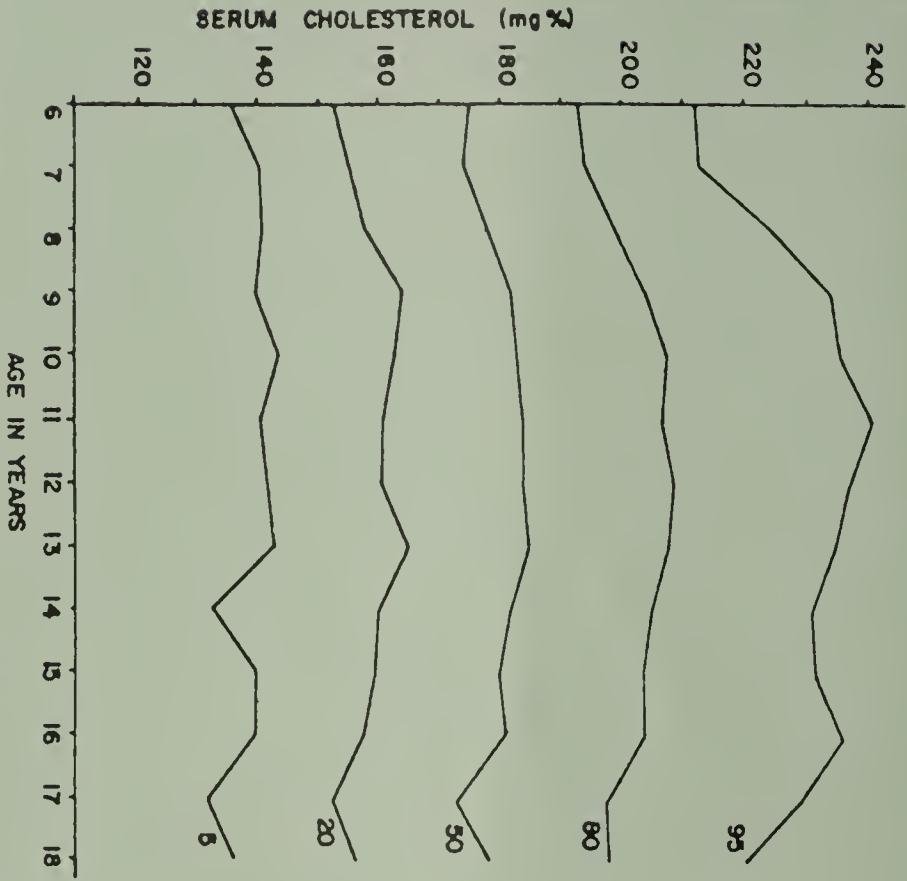


Fig. 1A. Selected percentiles of serum cholesterol levels for boys and girls ages 6 through 18 years. *N* indicates the number of children measured in each age group. There was little difference between the levels of cholesterol in boys and girls.

Serum cholesterol data done on Autoanalyzer I. Other data from normal subjects done by other methods. Plasma cholesterol may read significantly lower than these values shown.

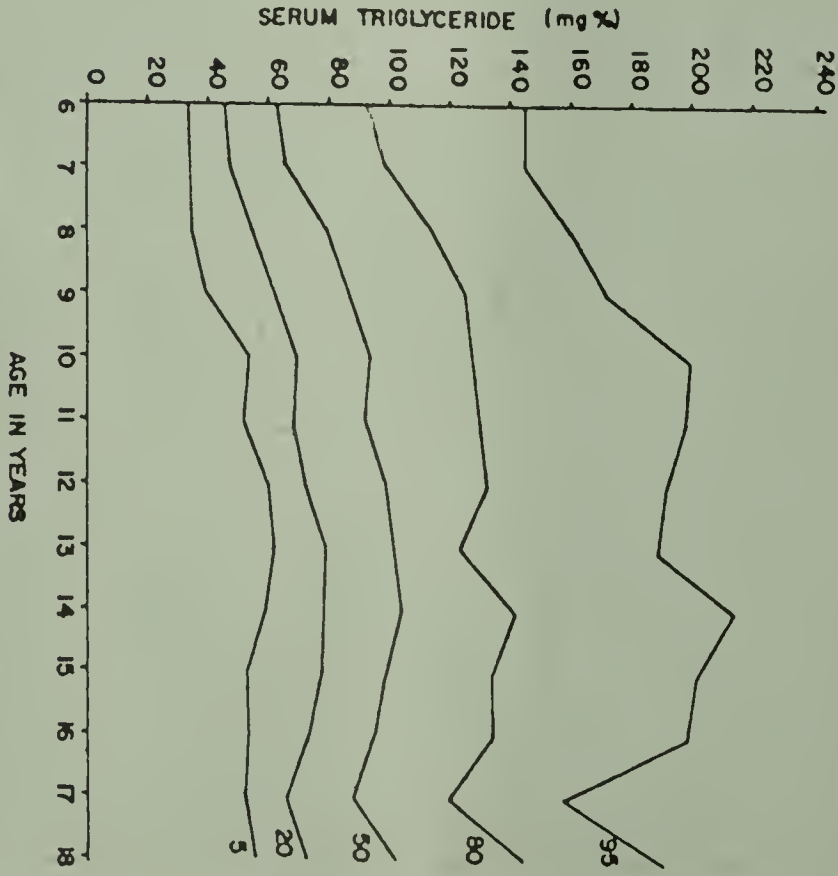
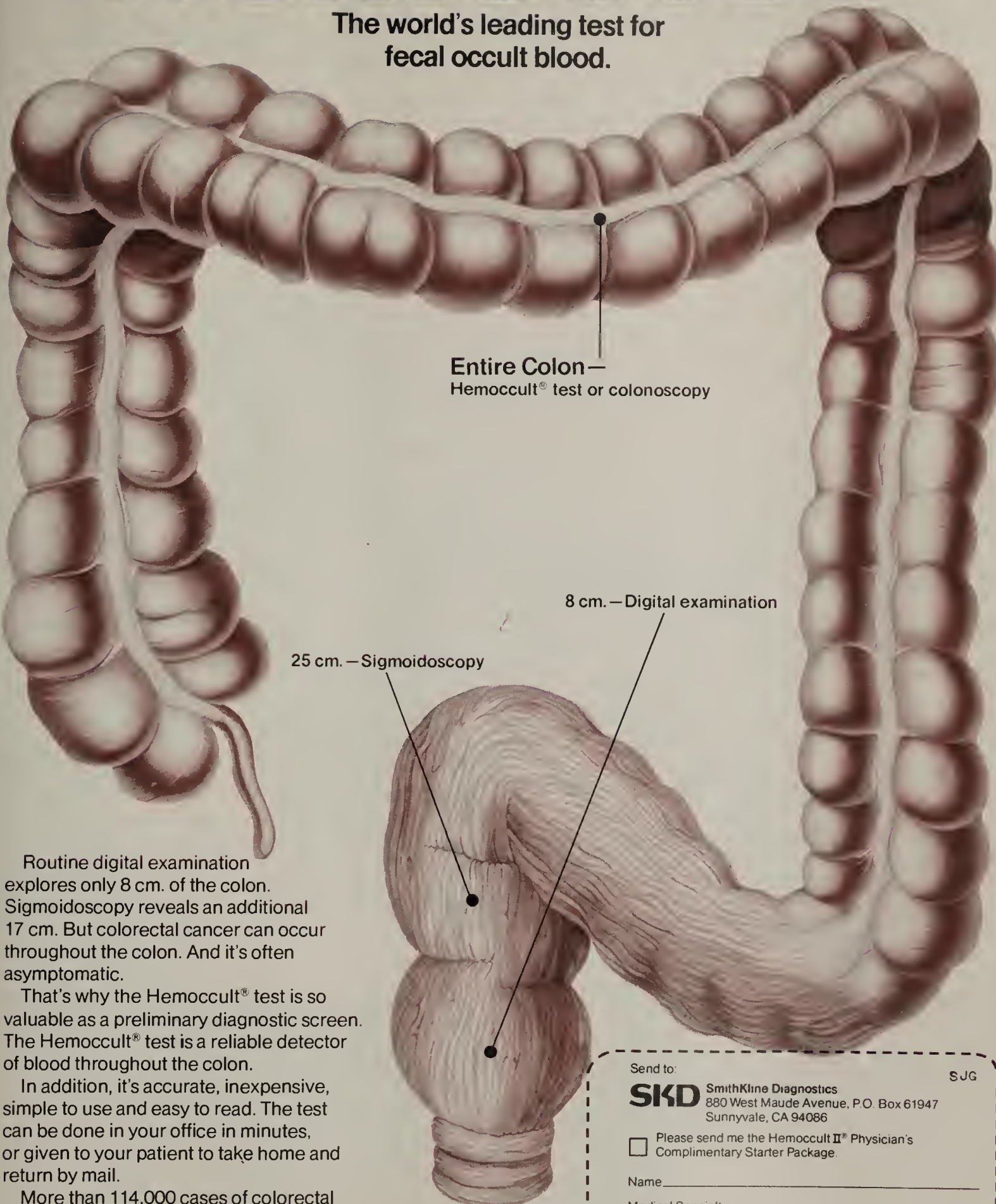


Fig. 2. Selected percentiles of serum triglyceride levels for boys and girls ages 6 through 18 years. *N* indicates the number of children measured in each age group. There was little difference between the levels of triglyceride in boys and girls.

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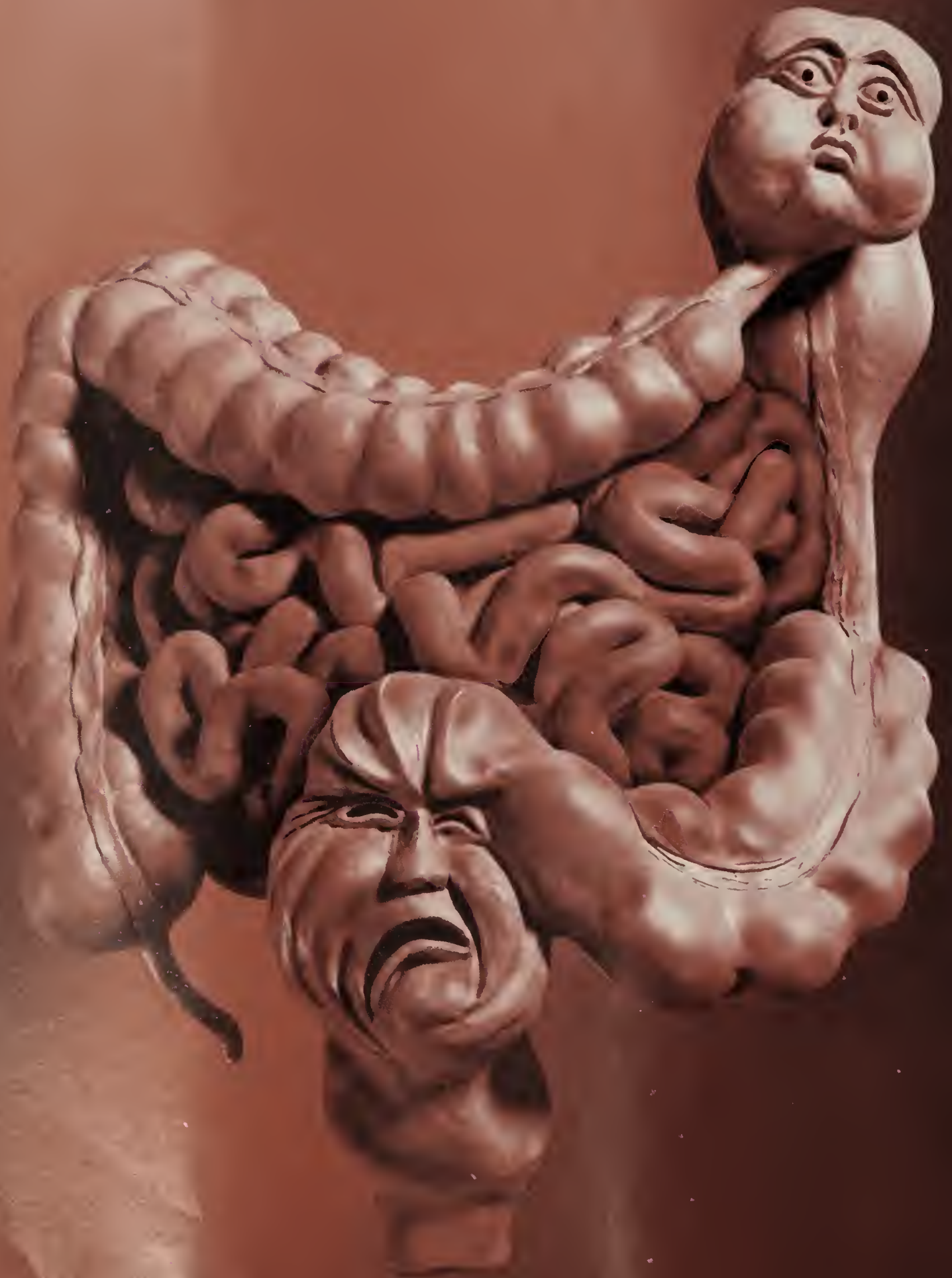
Medical Specialty _____

Address _____

City _____ State _____ Zip _____

Phone _____

**When painful spasm
is the presenting
symptom...**



...in the functional bowel/irritable bowel syndrome*

Bentyl®

(dicyclomine hydrochloride USP)

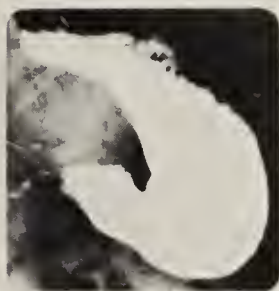
10 mg. capsules, 20 mg. tablets,
10 mg./5 ml. syrup, 10 mg./ml. injection

helps control abnormal motor activity
with minimal anticholinergic side effects†

Demonstrated smooth muscle relaxant activity.

In this double-blind study, twenty patients having G.I. series and exhibiting spasm were randomly selected to receive either 2 cc. of Bentyl or sodium chloride intramuscularly. Ten minutes after the injection another radiograph was taken . . .

. . . Bentyl produced definite relaxation in 8 of 10 patients. The sodium chloride produced relaxation in only 3 of 10. No side effects occurred in either group of patients.



Pylorospasm has almost totally blocked passage of barium meal.



Barium meal beginning to pass 10 minutes after intramuscular injection of 20 mg. Bentyl.

“The correlation of spasm relief and drug given was excellent.”

*This drug has been classified “probably” effective in treating functional bowel/irritable bowel syndrome

†See Warnings, Precautions and Adverse Reactions.

See following page for prescribing information.

Reference:
King, J.C. and Starkman, N.M.: Evaluation of an antispasmodic. Double-blind evaluation to control gastrointestinal spasms occurring during radiographic examination. A preliminary report. Western Med. 5:356-358, 1964.

Merrell

Bentyl[®]

(dicyclomine hydrochloride USP)

Capsules, Tablets, Syrup, Injection

AVAILABLE ONLY ON PRESCRIPTION

Brief Summary

INDICATIONS

Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the following indications as "probably" effective:

For the treatment of functional bowel/irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis.

THESE FUNCTIONAL DISORDERS ARE OFTEN RELIEVED BY VARYING COMBINATIONS OF SEDATIVE, REASSURANCE, PHYSICIAN INTEREST, AMELIORATION OF ENVIRONMENTAL FACTORS.

For use in the treatment of infant colic (syrup).

Final classification of the less-than-effective indications requires further investigation.

CONTRAINDICATIONS: Obstructive uropathy (for example, bladder neck obstruction due to prostatic hypertrophy); obstructive disease of the gastrointestinal tract (as in achalasia, pyloroduodenal stenosis); paralytic ileus, intestinal atony of the elderly or debilitated patient, unstable cardiovascular status in acute hemorrhage, severe ulcerative colitis; toxic megacolon complicating ulcerative colitis, myasthenia gravis. **WARNINGS:** In the presence of a high environmental temperature, heat prostration can occur with drug use (fever and heat stroke due to decreased sweating). Diarrhea may be an early symptom of incomplete intestinal obstruction, especially in patients with ileostomy or colostomy. In this instance treatment with this drug would be inappropriate and possibly harmful. Bentyl may produce drowsiness or blurred vision. In this event, the patient should be warned not to engage in activities requiring mental alertness such as operating a motor vehicle or other machinery or perform hazardous work while taking this drug. **PRECAUTIONS:** Although studies have failed to demonstrate adverse effects of dicyclomine hydrochloride in glaucoma or in patients with prostatic hypertrophy, it should be prescribed with caution in patients known to have or suspected of having glaucoma or prostatic hypertrophy. Use with caution in patients with: Autonomic neuropathy. Hepatic or renal disease. Ulcerative colitis. Large doses may suppress intestinal motility to the point of producing a paralytic ileus and the use of this drug may precipitate or aggravate the serious complication of toxic megacolon. Hyperthyroidism, coronary heart disease, congestive heart failure, cardiac arrhythmias, and hypertension. Hiatal hernia associated with reflux esophagitis since anticholinergic drugs may aggravate this condition.

Do not rely on the use of the drug in the presence of complication of biliary tract disease. Investigate any tachycardia before giving anticholinergic (atropine-like) drugs since they may increase the heart rate. With overdosage, a curare-like action may occur. **ADVERSE REACTIONS:** Anticholinergics/antispasmodics produce certain effects which may be physiologic or toxic depending upon the individual patient's response. The physician must delineate these. Adverse reactions may include xerostomia; urinary hesitancy and retention; blurred vision and tachycardia, palpitations; mydriasis, cycloplegia; increased ocular tension; loss of taste, headache, nervousness; drowsiness; weakness; dizziness; insomnia; nausea, vomiting, impotence, suppression of lactation; constipation, bloated feeling; severe allergic reaction or drug idiosyncrasies including anaphylaxis; urticaria and other dermal manifestations, some degree of mental confusion and/or excitement, especially in elderly persons, and decreased sweating. With the injectable form there may be a temporary sensation of lightheadedness and occasionally local irritation. **DOSEAGE AND ADMINISTRATION:** Dosage must be adjusted to individual patient's needs.

Usual Dosage: Bentyl 10 mg capsule and syrup. **Adults:** 1 or 2 capsules or teaspoonfuls syrup three or four times daily. **Children:** 1 capsule or teaspoonful syrup three or four times daily. **Infants:** ½ teaspoonful syrup three or four times daily (May be diluted with equal volume of water.) Bentyl 20 mg.: **Adults:** 1 tablet three or four times daily. Bentyl Injection: **Adults:** 2 ml. (20 mg.) every four to six hours intramuscularly only. **NOT FOR INTRAVENOUS USE.** **MANAGEMENT OF OVERDOSE:** The signs and symptoms of overdose are headache, nausea, vomiting, blurred vision, dilated pupils, hot, dry skin, dizziness, dryness of the mouth, difficulty in swallowing, CNS stimulation. Treatment should consist of gastric lavage, emetics, and activated charcoal. Barbiturates may be used either orally or intramuscularly for sedation but they should not be used if Bentyl with Phenobarbital has been ingested. If indicated, parenteral cholinergic agents such as Urecholine[®] (bethanecol chloride USP) should be used.

Product Information as of October, 1978

Injectable dosage forms manufactured by CONNAUGHT LABORATORIES, INC., Swiftwater, Pennsylvania 18370 or TAYLOR PHARMACAL COMPANY, Ocatator, Illinois 62525 for MERRELL-NATIONAL LABORATORIES, Division of Richardson-Merrell Inc., Cincinnati, Ohio 45215, U.S.A.

Merrell

MERRELL NATIONAL LABORATORIES
Division of Richardson-Merrell Inc.
Cincinnati, Ohio 45215 U.S.A.

Do you know

a physician
with problems
of alcoholism,
drug abuse,
or other
difficulties
which interfere with
his/her abilities
to practice medicine?

*If so, please contact
your MSMS Committee to
assist Impaired Physicians,
through Mert Scholten at MSMS
headquarters (517) 337-1351.*



Most striking find of MSMS survey: Medical malpractice suits increase in past five years

By John Richards, Chief, MSMS Bureau of Economics

The number of malpractice claims filed against physicians in Michigan has increased dramatically in the last decade.

Preliminary analysis of 906 claims completing the legal process between 1975 and July 1979 indicates a continuing increase in the number of claims filed. **Table one** displays this increase based on the year of the alleged injury. Since the average claim takes 48 months from the time of injury, it is expected the years 1976 to 1980 will continue this upward trend.

As a consequence of the increasing number of claims, the total payout also has increased dramatically (**Table two**). Unfortunately, since the data for

the years before 1975 cannot be considered complete, the actual magnitude of this increase cannot be accurately measured.

It is interesting to note that except for the years 1972 and 1973, the average payout per claim has remained relatively stable. There has been an increase in the number of suits with indemnity paid over \$50,000 in the last five years, but these have been offset in the average by the larger number of suits with no indemnity or small indemnity paid (**Table three**).

Concurrent with the increase in the number of claims and the total payout are increases in professional liability payments. Data gathered by

HEW indicate a 103 percent increase in premiums for Michigan between 1974 and 1977 as indicated in **Table four**.

The analysis does indicate a substantial reduction in the time required to complete a claim, while the time between the date of injury and the time it is reported has increased (**Table five**). It is very difficult to determine the reasons for this. Possibly the increase in the public awareness regarding the possibilities of litigation has increased to the point individuals are now reacting to situations previously unreported.

Other than the trends mentioned above, most other characteristics recorded by the closed claims survey have remained relatively constant in the past five to six years. Except for the year 1979, which is not complete, the

Table 1
Number of Claims by Year

	1970	1971	1972	1973	1974	1975	1976	1977	1978	1979(1/2)
Number of Claims	5	6	26	67	172	225	199	137	57	4

Table 2
Claims Characteristics

	1970	1971	1972	1973	1974	1975	1976	1977	1978	1979(1/2)
# of Claims	5	6	26	67	172	225	199	137	57	4
Total Paid	\$16,667	\$44,200	\$569,262	\$712,551	\$1,490,384	\$1,514,529	\$1,063,012	\$483,631	\$244,002	\$7,073
Average Paid	3,333	7,366	21,894	10,635	8,665	6,731	5,341	3,479	4,280	1,768
% No Indemnity Paid	(4)	(3)	(11)	(29)	(80)	(109)	(102)	(68)	(29)	(1)
	80%	50%	42%	43%	47%	48%	51%	49%	51%	25%

average age of the physician involved in a claim is 43 years. As evidenced by **Table six** this figure has not varied greatly over the last five years.

The average for board certified physicians named in suits is 67 percent. This average is different for each year, but does not indicate any trend as it increases and decreases randomly. This also holds true for type of practice, with physicians in PCs and self-employed the most likely to be sued. General practitioners and surgeons are the most frequent targets of legal actions. This fact has not varied greatly over time, these specialties generally accounting for approximately 50 percent of the actions in any year (**Table seven**).

The geographic distribution of the claims continues to indicate the majority come from Wayne, Oakland and Macomb counties.

It is possible to conclude from this information the most striking feature of the professional liability issues is the substantial increase in the number of claims being filed. As a result of the increase in the total number, there have been substantial increases in the total payout and malpractice premiums. Most of the other factors for which data are available have remained relatively constant or varied randomly.

Great caution must be used when interpreting this information. The total number of suits studied is relatively small and much of the data, especially before 1975, are not reliable.

The MSMS Bureau of Economics will continue to collect data and analyze it to increase our knowledge concerning this subject. Long term trends based on sufficient numbers of cases will assist MSMS in its efforts to address the basic causes of the problem and work toward their resolution.

Table 4
Percentage Change in Premiums by State
for 1974-75, 1975-76 and 1976-77

State	1974- 1975	1975- 1976	1976- 1977
Alabama	40%	19%	319%
Alaska	NI	NI	NI
Arizona	109	115	50
Arkansas	40	63	4
California	145	147	0
Colorado	38	63	0
Connecticut	38	10	2
Delaware	71	0	-3
District of Columbia	40	108	0
Florida	286	0	33
Georgia	25	65	26
Hawaii	70	84	13
Idaho	62	-42	8
Illinois	78	110	6
Indiana	47	0	17
Iowa	62	0	17
Kansas	68	-58	17
Kentucky	76	0	17
Louisiana	90	75	37
Maine	NI	0	29
Maryland	40	65	0
Massachusetts	12	0	7
Michigan	86	0	17
Minnesota	49	-34	-4
Mississippi	25	96	21
Missouri	68	0	17
Montana	77	38	0
Nebraska	58	47	-8
Nevada	95	0	NI
New Hampshire	NI	0	NI
New Jersey	47	55	0
New Mexico	84	60	25
New York	54	7	16
North Carolina	46	11	-5
North Dakota	19	57	-2
Ohio	66	33	17
Oklahoma	NI	35	27
Oregon	15	20	0
Pennsylvania	97	0	17
Rhode Island	70	-7	0
South Carolina	72	26	50
South Dakota	37	63	0
Tennessee	193	128	-48
Texas	109	16	17
Utah	67	0	-1
Vermont	157	0	-1
Virginia	NI	-8	-1
Washington	55	33	6
West Virginia	53	25	5
Wisconsin	36	0	17
Wyoming	191	22	0

Source: Telephone Survey of Malpractice Insurance Companies conducted by HCFA.

Table 3
Distribution By Thousands
of Indemnity Paid

	1970	1971	1972	1973	1974	1975	1976	1977	1978	1979(1/2)
\$ 0- 10	0	2	4	23	61	90	83	63	23	3
\$ 11- 20	1	0	3	5	9	14	5	3	3	0
\$ 21- 30	0	0	1	4	8	2	2	1	1	0
\$ 31- 40	0	1	0	2	2	1	0	1	0	0
\$ 41- 50	0	0	2	2	4	1	1	1	0	0
\$ 51- 60	0	0	1	0	0	1	0	1	0	0
\$ 61- 70	0	0	2	0	1	0	0	0	0	0
\$ 71- 80	0	0	0	1	2	1	0	1	0	0
\$ 81- 90	0	0	1	0	1	0	2	0	0	0
\$ 91-100	0	0	0	0	4	4	2	0	1	0
\$101-200	0	0	1	1	0	2	2	0	0	0

Table 5
Claims Reporting Data

YEAR	1970	1971	1972	1973	1974	1975	1976	1977	1978	1979(1/2)
Number of Cases	5	6	26	67	172	225	199	139	57	4
Avg. # of Mos. — Injury to Report	10	12	16	24	21	20	22	31	31	33
Avg. # of Mos. — Injury to Close	85	69	73	68	58	44	39	41	36	33
Avg. # of Mos. — Report to Close	75	57	56	44	37	25	17	11	5	1

Table 6
Physician Characteristics

	1970	1971	1972	1973	1974	1975	1976	1977	1978	1979(1/2)
Average Age of Physician	32	39	40	38	42	42	41	41	45	52
Physician Age Distribution										
30 and under	25%	20%	0	0	1%	2%	<1%	<1%	<1%	0
31-40	25%	0	27%	24%	29%	30%	31%	39%	21%	0
41-50	50%	40%	41%	53%	39%	36%	35%	34%	54%	50%
51-60	0	40%	23%	16%	28%	21%	20%	20%	14%	50%
60 and over	0	0	9%	7%	3%	10%	14%	6%	8%	0
% of FMGs	N/A	33%	4%	7%	17%	18%	16%	19%	18%	N/A
Board Certified	(4)	(5)	(15)	(29)	(119)	(141)	(137)	(84)	(29)	(2)
	80%	83%	58%	43%	69%	63%	69%	60%	51%	50%

Table 7
Claims Against Physicians
By Type of Practice

Year	1970	1971	1972	1973	1974	1975	1976	1977	1978	1979(1/2)
Type of Practice										
Institutional	0	1	1	0	2	2	3	4	0	0
PC/Partnership	0	2	8	21	58	84	65	42	25	2
Self-Employed	5	3	16	41	103	127	121	80	29	2
Employed	0	0	1	5	7	10	9	10	3	0
Intern/Resident	0	0	0	0	0	0	0	0	0	0

MPMLC serves Michigan MDs in ways no other company can

By Martha Smith, special to Michigan Medicine



The Michigan Physicians Mutual Liability Company's innovative policies are being well received. The company's steady growth begs the question of why the MPMLC is so attractive to MSMS members.

Since its inception in 1976, the pioneering professional liability company's assets have grown to exceed \$49 million, with a surplus of over \$9 million. In addition, the Michigan insurance commissioner has just authorized the non-assessable mutual insurance company to offer any type of property-casualty insurance.

Any member of the Michigan State Medical Society is eligible for membership.

Lowest premiums

MPMLC ultimately hopes to have the lowest possible premium structure.

According to William Cheeseman, MPMLC's administrative director, this goal is based on three major attributes of the company. First, MPMLC is a mutual insurance company, is therefore concerned with covering operating costs and does not make allowances for profit. Second, good management keeps these operating costs at a minimum. Third, sound judgement made on thoroughly investigated claims, results in the proper allocation of the company's funds and resources.

One of the greatest advantages MPMLC offers is its expert full-time staff of claims investigators. These

people deal exclusively in Michigan malpractice suits. They are knowledgeable in medical vocabulary and terms and therefore can be more understanding and helpful. Investigative work is not "farmed out," as it might be in other corporations, for the sake of convenience. Another characteristic of MPMLC, which is unique to the professional liability field, is that all decisions on claims are made in-state.

The MPMLC claims staff begins investigating a suit within three days of its reporting, sparing the doctor the anxiety of delayed action.

Once the facts are collected, a board of physicians qualified to evaluate the situation and conditions of the plaintiff's claim, works with staff to determine the best position the company should take in representing the doctor involved.

If the doctor's actions are upheld, MPMLC will defend frivolous suits, disregarding higher court costs, to protect the doctor's integrity and reputation. This is not always the case with other, more economically-minded, insurance firms.

Controlled confidentiality is another characterization of the MPMLC's small, specialized staff. Larger, more decentralized insurance companies may have difficulty controlling information.

MPMLC was established for Michigan physicians exclusively to deal with their specific malpractice problems. Because of this, doctors are offered tailor-made policies that meet their needs.

Underwriting is done in the best interest of the physician. Those qualified to evaluate a doctor's individual practice, past experience, or previous suits determine surcharges after a peer review procedure. These conditions, unique to each physician, are taken into account before the addition of any surcharges.

In reference to this procedure, Mr. Cheeseman says, "MPMLC represents a marriage between sound medical people who keep the company on track, and capable administrators who can efficiently carry out their decisions. Both groups are expert and don't interfere in one another's operations."

Impetus for change

Traditionally, conservative views and practices have restricted the insurance industry.

MPMLC takes pride in being the impetus for change. It was first to offer a 50 percent discount on premiums to doctors in their first year of private practice and to those anticipating retirement.

Also, MPMLC offers coverage based on a newly-developed theory for classifying specialties. MPMLC was first in Michigan to reintroduce higher policy limits of \$200,000 per occurrence and \$600,000 aggregate, following the mid-70's liability insurance crisis.

A new type of office policy now being offered by MPMLC is MED-GARDTM. It includes coverage for reconstructing patient records, loss of earnings, tenant improvements, employee dishonesty, and a number of other options. In the future, MPMLC plans to offer complementary policies at favorable rates and with extra advantages.

Because preventing malpractice is vital to keeping premiums down, MPMLC also offers suggestions for improving patient safety, avoiding malpractice pitfalls, building a stronger defense in suits, and implementing risk management programs. The company has sponsored various programs designed to educate physicians in the areas of their practice where safeguards against malpractice are most effective. These include more efficient record-keeping and improved doctor-patient relationships and communication.

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Modern medical practice has become a complex and time-consuming operation. Too often the physician sacrifices leisure time and family responsibilities to his professional duties.

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To attract quality physicians, the Air Force has assembled an excellent package of compensation and entitlements. These include 30 days of paid vacation each year, an opportunity to seek specialization at Air Force expense, and full medical and dental care without loss of pay during treatment.

We would like to provide more information about Air Force medicine. Contact Air Force Medical Opportunities, 23400 Michigan Ave., Dearborn, 48124. (313/561-7018). We'll answer your questions promptly and without obligation.

AIR FORCE. HEALTH CARE AT ITS BEST.

Well-planned filing system keeps management problems minimal

By R. Timothy Hogan, CPBC

Do you ever try to return a patient's call only to discover one of the charts is missing and you can't recall the specifics?

Are you running out of room for the filing cabinets and wondering where to put new ones?

No doctor wants to bother with the mundane details of running the office, but a poor filing system will consume time, energy, and space you can't spare. A well-conceived system will allow you to relegate filing to its proper place — the background — while you get on with caring for patients.

Cabinets

A good filing system starts with cabinet selection. The choice is shelves or drawers. In general, shelf filing is more convenient and takes about 50 percent less room. With the escalating cost of professional office space it's important to take advantage of every square inch you have.

Sets

Experience has shown that clinical and business records serve quite different functions and should be maintained separately. If the two sets are kept together, it is inevitable that both you and your aides are going to find the records you want are in use

elsewhere when you need them.

Besides, cluttering the chart files with irrelevant financial material only makes the essential details of treatment harder to dig out.

Alphabetical

Having decided to separate the clinical and financial records, you have still another choice to make. Should the records be filed alphabetically or numerically? Most offices file alphabetically, and in the majority of cases this is the right decision, even though the doctor may not be aware of an alternative.

In numerical filing, each patient is assigned an identification number which is entered on the financial and clinical folder in place of the name. The records are then filed in numerical sequence.

Advocates maintain numerical filing makes it easier to return folders to their proper place, thereby increasing filing speed and cutting down on the incidence of misfiled records. Another selling point is that filing by number eliminates the confusion that can arise when two patients have the same name.

Unfortunately, patients frequently forget their number or misplace their ID card. In order to locate the records the receptionist must keep a separate alphabetical index for looking up missing numbers. The additional effort involved in maintaining the index and looking for numbers usually cancels any benefits of speed the system affords.

Misfiling still occurs with a numerical system. Eliminating duplication of names is not a material advantage since such repetition seldom occurs except in the largest clinics.

The small practice is usually better off with alphabetical filing.

Colors

Color coding is a technique many offices have found helpful to reduce misfiling.

In color coding, folders in a dozen or so readily distinguishable colors are divided among the alphabet.

If the A folders are red, and the S folders green, it will be harder to put Mrs. Anderson's folder in Mrs. Sanderson's slot. If the mistake occurs due to haste or carelessness, Mrs. Anderson's red folder will stand out among the green S's and be easier to retrieve.

Color coding an already existing set of files can be a time-consuming job and easy to put off. So if you're thinking of making the conversion, don't wait for a good time — there isn't one. If you don't want to buy new folders and throw away your old ones, preglued colored tabs are available which can be attached to your present folders.

Purging

Eventually, even the best filing system becomes glutted. Individual folders bulge, charts multiply, and cabinet space dwindles alarmingly.

If the filing area in your office is getting uncomfortably cramped, but you haven't been purging your files on a regular basis, your problem can probably be solved by dividing your files into active and inactive.

How often files should be purged can vary considerably with patient load and the length of time patients usually remain active. But whatever schedule you eventually work out should call for transferring files before your space problem becomes acute.

The biggest difficulty in purging the files, and the one that leads to postponing the job, is determining when patients last came in. Stamping the date on each visit on the outside of the folder is a simple and effective way to avoid leafing through each chart.

Mr. Hogan is management consultant with Professional Management, Ann Arbor, and with Black and Skaggs Associates, Battle Creek.

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Auxiliary's Legislative Day April 21 in Lansing

By Mildred Carron, Ann Arbor



Michigan's medical families have the opportunity April 21 to learn about legislation that will affect medicine.

That is the date of the annual MSMS Auxiliary's Legislative Day.

planned this year at Kellogg Center, Michigan State University, East Lansing.

Physicians' spouses who attend will hear MSMS and AMA staff experts, MSMS President Ernest P. Griffin, Jr., MD, and State Sen. Edward Pierce, MD, the only medical doctor currently serving in the Michigan legislature. Doctor Pierce will make candid observations on his experiences as a physician in politics.

Legislation Day is one of the best attended auxiliary functions. Chairman this year is Barbara (Mrs. Donald E.) Wild, Ann Arbor, who also serves as MSMS-A legislative chairman.

To prepare those physicians and spouses who plan to attend the Legis-

lative Day, Mrs. Wild announces the following major topics:

1) The new State Public Health Code.

2) National health insurance, including Carter, Kennedy, Long and Ullman proposals, and the administration's cost containment proposal.

3) The coming national elections.

4) Legislation proposing Michigan Blue Cross Blue Shield reform.

5) Other state bills defining an expert witness for a malpractice trial and providing psychiatric benefits under all governmental and private insurance programs.

6) The Michigan Doctors Political Action Committee and the American Medical Political Action Committee. Michigan has an AMPAC board member, Thomas R. Berglund, MD, Portage, whose wife, Auxilian Jill Berglund, sits on the MDPAC board. Thomas C. Payne, MD, Lansing, is MDPAC chairman.

Auxiliary members will be urged to make contributions to MDPAC and AMPAC, which give medical families a voice in government. MDPAC memberships are \$50, and \$25 of that amount goes to AMPAC. Sustaining memberships are \$150, with \$100 for MDPAC and \$50 for AMPAC. Tax credits are permitted on 1980 federal and state income tax returns.

"Medicine continues to face several crises," says Doctor Payne. "1980 elections will set the legislative and political tone for the next decade." He asks auxiliary members to participate more actively.

Luncheon with auxiliary members' local legislators will follow the Legislative Day morning meeting. Mrs. Caroline Rich, MSMS-A executive secretary, will take reservations until April 14 at MSMS headquarters, 120 W. Saginaw St., East Lansing, 48823 (telephone: 517/337-1351).

Join 'the winning team' for AMA-ERF!

"The Winning Team" is the 1980 theme for each of us who supports the American Medical Association's Education and Research Foundation (AMA-ERF) with a contribution. This is tax deductible.

Last year more than 4,000 medical students and physicians-in-training borrowed \$5.8 million from AMA-ERF. Foundation President Hubert A. Ritter, MD, says, "Costs are putting tremendous pressures on medical students." He would like to see many more physicians become involved.

For every dollar contributed, a participating bank will loan \$12.50. A contribution guarantees that the loan and interest will be repaid. Each medical school is limited to 50 loans. Last year \$1.6 million were given by physicians and their families. AMA Auxiliaries raised \$1.1 million of the above amount.

In Michigan, we raise most of our contributions selling holiday greeting

cards. We raised \$22,000 this way last year. If a county auxiliary selects AMA-ERF as a project, it may give the average cost of its official holiday greetings to AMA-ERF and the county auxiliary will select and send an attractive card to each medical family in the county, listing names of contributors. These contributors are "the winning team."

Physicians' families also may give money to a medical school. They may just name it — or any medical school in the United States and Canada. Funds that are not designated for a particular medical school or the loan fund will be equally divided for the three Michigan medical schools.

From 1978 contributions, U-M received \$17,487.24; Wayne State U received \$10,915.51; and MSU received \$4,925.57. In Michigan, 165 loans were given to students and eight to physicians-in-training in 1978. Since 1963, 3,314 loans have been given in Michigan totaling \$4,297,590.

Medical schools need physicians' families' support. Won't you join "the winning team?"

Mrs. Carron is president of the MSMS Auxiliary.



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NEWS

By Katie Brewbaker, MSMS staff



Doctor DeJong



Doctor Tanner



Doctor Taylor



Doctor Weg

Roscoe V. Stuber, MD, Howell, is a new member of the board of directors of the American Cancer Society. He is a past president of the Michigan Division of ACS . . . Governor Milliken has appointed **Edward J. Klopp, MD**, Battle Creek, to the Michigan Certificate of Need Board . . . Elected to the board of governors of the American College of Surgeons is **Tommy N. Evans, MD**, Detroit, for a term to expire in 1982 . . . **David S. Greenbaum, MD**, of the MSU College of Medicine, Department of Medicine, is recipient of a Distinguished Faculty Award by the University . . . Over 400 people paid tribute to **Thomas Bass, MD**, Ypsilanti, at what was expected to be a small retirement party at the Eastern Michigan University campus. Doctor Bass gave time to the community through the Boy Scouts, his church, the NAACP, and Ypsilanti Human Relations Commission . . . Jackson citizens will feel a void as two of their doctors announce retirement. **Richard C. Deming, MD**, and **John W. Rice, MD**, are turning their practices over to new physicians. Both were subjects of extensive articles in the Jackson Citizen Patriot . . . **Harley H. Anderson, MD**, Mt. Morris, is packing up 33 years of memories as he retires from practice. He wants to get back into community service and is considering overseas medical-missionary work . . . **Eugene W. Hildebrand, MD**, Grand Marais, has been in the Philippine Islands where he helped set up a medical-dental program on the Bataan Peninsula . . . **Robert L. Tupper, MD**, Grand Rapids, is a member of the AMA's committee on CME accreditation (CACME). Doctor Tupper served on the Review Committee of the Liaison Committee in Continuing Medical Education

since 1977 and for several years was chairman of the AMA CME survey teams . . . Only two neurologists in the United States ever have been honorary members of the American Neurological Association, and **Russell N. DeJong, MD**, professor emeritus of neurology at the U-M Medical School, is one. Doctor DeJong is a founding member of the World Federation of Neurology. The fourth edition of his book, "The Neurologic Examination, Incorporating the Fundamentals of Neuroanatomy and Neurophysiology," has just been released by Harper and Row . . . **Eric D. Austad, MD**, U-M plastic surgeon, is recipient of the top research award from the American Society of Plastic and Reconstructive Surgery for a new technique to provide closely-matching donor tissue in reconstruction of the breasts and for head and neck surgery . . . **Natalia Tanner, MD**, Detroit pediatrician and ephebiatrician, was featured in a recent issue of the Detroit Free Press's "Detroiter Sunday" supplement as exemplifying the new vitality of the Motor City . . . **W. E. Maldonado, MD**, Lansing, is reappointed to the Michigan Blood Council for another two-year term . . . **W. Donald Weston, MD**, Dean of MSU's College of Human Medicine, is recipient of the Outstanding Service Award by the Upper Peninsula Health Education Corporation for his development of the concepts embodied in the Upper Peninsula Medical Education Program . . . The Dermatology Foundation named **William B. Taylor, MD**, Ann Arbor, winner of the 1980 Clark W. Finnerud Award for teaching and research. The Dermatology Foundation reports when Doctor Taylor's name was placed in nomination for the award,

the Foundation was deluged by letters of support for this "superb clinical physician, excellent teacher and humanist." . . . **William M. Lukash, MD**, Detroit native and personal physician to President Carter, received an honorary doctor of science degree from Michigan State University at its winter commencement exercises . . . The pediatric center at Hurley Medical Center has been named for **Arthur L. Tuuri, MD**, the Flint physician instrumental in establishing the center which provides free or low-cost health care to thousands of area youngsters . . . **Vainutis K. Vaitkevicius, MD**, chairman of the department of oncology at the WSU School of Medicine, is recipient of the 1980 Leo M. Franklin Award in Human Relations presented by WSU and Temple Beth El. He was recognized because, "Human relations has been uppermost during all of Doctor Vaitkevicius' professional career." . . . President-elect of the American College of Chest Physicians is **John G. Weg, MD**, professor of internal medicine and physician-in-charge of the pulmonary division at the U-M School of Medicine. He will take office in the fall of 1980 . . . Elected vice-chairman of the board of governors of the American College of Surgeons is **Alexander J. Walt, MD**, professor and chairman of the department of surgery at WSU School of Medicine. Doctor Walt also serves on the executive committee and the board of Regents of the college . . . **Robert Wilson, MD**, of Bloomfield Hills, is president-elect of the Michigan Chapter of the American College of Surgeons. Doctor Wilson is director of thoracic and cardiovascular surgery at Harper-Grace Hospital, director of the hospital's surgical intensive care units and coordinator of the emergency room . . . **Delores J. Shelfohn, MD**, Bloomfield Hills general surgeon specializing in emergency medicine, is new second vice president of the American Medical Women's Association and chairman of the AMWA Committee on Publicity and Public Relations.

NEW MEMBERS



Members of the Michigan State Medical Society join in welcoming the following new members into a progressive state medical organization. MSMS is dedicated to promoting the science and art of medicine, the protection of the public health, and the betterment of the medical profession. Each new member is encouraged to join with other MSMS members at both the local and state levels in achieving these goals.

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4015 Mar Moor
Lansing, 48917

Napoleon N. Capili, MD AN
16260 Dexter Blvd.
Detroit, 48221

Mitchell J. Carey, MD FP
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East Jordan, 49727

John F. Cotant, Jr., MD CD/IM
880 S. Woodward Ave. #101
Pontiac, 48053

Sunil Kumar Das, MD PD
2487 Darfield
Rochester, 48063

Terence C. Davies, MD FP
U of M Med. School Dept. FP
Ann Arbor, 48109

John M. Garrett, MD OPH/IM
Commercial Bank Bldg.
Iron Mountain, 49801

Jose A. Gonzalez, MD U
1915 E. 14 Mile Rd.
Birmingham, 48008

Lynn S. Gray, MD FP/EM
997 Agard Ave.
Benton Harbor, 49022

Harry S. Greenberg, MD N
U of M Dept. Neurology
Ann Arbor, 48109

Yousif I. Hamati, MD
1560 E. Sherman Blvd.
Muskegon, 49444

Michael I. Hertz, MD
22120 Fairway Dr.
Southfield, 48034

Anne B. Hill, MD AN
S6344 U of M Hosp. Dept. AN
Ann Arbor, 48109

Yuh-Lin Hung, MD PD
1050 S. Van Dyke Rd.
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551 Linn St.
Allegan, 49010

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120 N. Jackson St. #4
Sandusky, 49471

Si Young Kim, MD AN
67 Cass Ave. #709
Mt. Clemens, 48043

Kyung-Ro Kwak, MD PD
802 S. Main St.
Cheboygan, 49721

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Royal Oak, 48072

Sajida M. Mirza, MD A/IM
23023 Orchard Lake Rd.
Farmington, 48024

Donald F. Moylam, MD U
501 Wm. Beaumont Med. Bldg.
Royal Oak, 48072

Sachiko K. Okamoto, MD GS
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Muskegon Heights, 49444

Dana D. Panknin, MD FP
456 W. Baldwin
Alpena, 49707

Charles R. Pollard, MD FP
Mason Medical Center #17
Ludington, 49431

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MSMS Q/A

Questions on a wide variety of topics are asked daily of MSMS staff and leaders. They in turn draw on many expert resources to help MSMS members get good information. To better inform the membership, sample questions, with answers, are printed here. Future issues will carry more.



**FOR: Richard W. Pomeroy, MD, Chairman
MSMS Committee on CME Accreditation**

"What is the present situation with the AMA's new Committee on Accreditation of Continuing Medical Education (CACME) and the Liaison Committee on Continuing Medical Education? Who actually approves CME courses in Michigan?"

AMA delegates in July voted to withdraw the AMA (it was one of seven parent organizations) from LCCME, after they were convinced that LCCME policies significantly reduced the role of the AMA and state medical associations in the accrediting process. The AMA has returned to its original role as a primary accreditor of CME-sponsoring organizations, an activity it carried on for 10 years. As it stands now, both the AMA and the LCCME are accrediting groups which sponsor national and regional CME meeting, and both have empowered state CME bodies (in Michigan the MSMS Committee on CME Accreditation) to accredit intra-state providers.

Thus, in Michigan, any CME provider surveyed and approved by the MSMS Committee on CME Accreditation is considered accredited by both the AMA and LCCME. The Michigan Board of Medicine always has considered the committee the accrediting body in the state. The AMA and LCCME directly approve institutions with national audiences (such as university medical schools), while MSMS approves organizations, such as hospitals, which are planning local intra-state CME programs.



**FOR: Thomas C. Payne, MD, Chairman
MSMS Committee on Public Service**

"Whatever happened to 'Housecall,' the phone-in medical question and answer program which used to be broadcast monthly by Channel 56 in Detroit?"

With a change in management this summer, Channel 56 decided to drop all its call-in format programs. That left physicians, lawyers, dentists and accountants without their continuing series of live programs. MSMS had responsibility for arranging the on-camera panels of physicians, and crews of medical assistants and other interested persons answering telephone calls. The popular program, which averaged 150 phone calls per half-hour show, was jointly supported by MSMS and Wayne, Oakland and Macomb county medical societies. Similar programs continue, however, on public television stations in Grand Rapids, the Delta Valley and Marquette.



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Nobel laureate to speak at Beaumont Lecture April 7



Doctor Smith

A former Michigan physician who received the Nobel Prize two years ago will deliver the 1980 Beaumont Lecture of the Wayne County Medical Society.

The event is scheduled April 7 in the Buerki Auditorium of Henry Ford Hospital, Detroit. The evening will begin with a reception at 6 p.m., followed by a dinner and the lecture.

The speaker is Hamilton O. Smith, MD, professor of microbiology at Johns Hopkins University. His topic will be "Restrictive Enzymes as Tools for Genetic Research."

Doctor Smith was co-winner of the Nobel Prize in 1978, along with Daniel Nathans, MD, chairman of the Johns Hopkins Department of Microbiology, and Werner Arber, MD, of the University of Basel, Switzerland. They received the prize for their work on how genes determine heredity.

Doctor Smith returns to Detroit for the Beaumont Lecture, as he formerly was a Henry Ford Hospital house officer from 1959-62. He was a post-doctoral fellow in genetics at the University of Michigan from 1962-76 and also worked with the U.S. Public Health Service in Michigan.

Reservations for the Beaumont Lecture are necessary. Interested physicians should telephone the Wayne County Medical Society at 313-567-1640.

Appropriate use, not limits, holds down health costs

A recently released Robert Wood Johnson Foundation Report finds emphasis on restricting high cost medical technology is less effective as a cost containment strategy than focusing on the appropriate use of all diagnostic technologies.

This announcement questions the focus of health planning agencies who have attempted to limit the expansion of high priced technology as a cost containment effort. The Johnson report states that if use of the four most costly technologies were reduced by 50 percent, the net savings would be less than 1 percent of the health care bill.

The alternative suggested in the Johnson report was to focus on the appropriate use of all technologies. This includes training medical students to select their use of technologies and restructuring the reimbursement system so the use of technology is not rewarded.

"The time has come . . . to allow physicians to choose either a low technology or a high technology practice without penalties for technologic restraint."

A related article appears in the Dec. 27 issue of New England Journal of Medicine.

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Here's what's happened since 1979 MSMS House of Delegates met



The MSMS House of Delegates convenes again in a month. The 1980 meeting is scheduled April 25-27 at the Michigan Inn in Southfield.

To bring members up to date on what has happened to resolutions of the 1979 session, *Michigan Medicine* prints the following summary of several key resolutions and actions.

15-79A Joint Commission on Accreditation of Hospitals.

This resolution directed that MSMS recommend that JCAH and other accrediting bodies agree on one set of goals and standards to be achieved by one inspection and that this recommendation be relayed to JCAH and other appropriate accrediting bodies.

MSMS sent letters to the JCAH president, the director of the Michigan Department of Public Health and to the Michigan Hospital Association president.

MSMS learned from JCAH President John E. Affeldt, MD, that "JCAH staff has been instructed to cooperate with state licensing/certification agencies and state medical and hospital associations to reduce and avoid duplication measures . . ." Doctor Affeldt also indicated that discussions were being held with the Michigan Department of Public Health and the Michigan Hospital Association regarding a joint single survey for hospitals.

23-79A HSA physician advisory committees.

The MSMS Physician/HSA Support Center has been instrumental in organizing physician committees to involve physicians in health planning as directed by this resolution. Physician groups have been developed in Mason, Grand Rapids and Petoskey. Organizational efforts are under way in Flint and Saginaw. There has been no activity to date in Kalamazoo or the Upper Peninsula.

The HSA Support Center is keeping physician health planning committees apprised of health planning activities. All physician health plan-

ners have been added to the mailing list for the AMA's *Health Planning Bulletin*. The Support Center publishes a monthly health planning column in *Michigan Medicine*. The Physician/HSA Support Center also has published a Health Planning Manual for Physicians to supply information on the health planning process and will produce supplemental materials when appropriate.

26-79A Modification of CME mandated by the state.

This resolution advocated modifying all portions of the new Public Health Code dealing with mandated continuing medical education.

This resolution was reviewed by a subcommittee made up of representatives of the MSMS Liaison Committee with the Board of Medicine and the Board of Medicine. Subsequently, new guidelines were jointly adopted by the MSMS Committee and the Board of Medicine.

The resolution also directed the MSMS Committee on CME Accreditation to review the categories of CME for the purpose of developing greater latitude in acquiring CME credit.

There is an effort at the national level to review and revise the categories of CME. Since nearly all state licensing requirements and voluntary programs are based on the AMA Physician's Recognition Award, it would be most appropriate that the Committee on CME Accreditation await national action, then encourage the Board of Medicine to adjust the categories accordingly. The Committee, through its Chairman, will make every effort to influence the review of the categories of CME at the national level to attempt to develop greater latitude in acquiring CME credit.

30-79A Uniform standards of medical professional liability insurance.

This resolution instructs MSMS to investigate the feasibility of providing peer review insurance for physicians who participate in peer review activities.

The resolution has been referred to the Michigan Physicians Mutual Liability Company with the request that it consider this as a new line of business.

The resolution also directed the distribution to all members and all hospitals of copies of Act 119 of 1975 with a lay language analysis.

This analysis was published in *Michigan Medicine* in August, and many reprints were distributed to physicians and hospitals.

32-79A Health maintenance organizations.

This resolution directed MSMS to continue to cooperate fully with the AMA HMO Study Project.

The MSMS staff has been in contact with the AMA regarding future cooperation on this project.

The resolution also instructs The Council to consider the creation of an HMO Support Center.

The Council has reorganized the Bureau of Economics to include a task force on HMOs. This task force will be charged with developing a specific action plan and outlining activities which will serve physicians involved with HMO/IPAs. When the report of the task force is complete and approved by The Council, MSMS will become actively engaged in carrying out these directives.

35-79A Cost containment through uniform claim form.

This resolution resolved that the MSMS House of Delegates support the AMA's effort to implement a uniform claim form for all third party payors.

MSMS has remained in contact with the AMA and has encouraged its efforts to develop a uniform processing system. Major changes in the diagnostic and procedure codes are expected to take place in 1980, having a direct impact on the claims form design. When changes occur to accommodate the new coding system, MSMS

will encourage the AMA to develop a form to be used by all third party carriers.

36-79A Improved communications for non-member recruitment.

This resolution directs The Council to investigate ways to improve communications with MDs who are not members of MSMS in an effort to inform and recruit.

This resolution is at the heart of the activity of the new Committee on Membership Recruitment and Retention, currently developing a program of reaching non-members. The AMA is intimately involved with this effort, using Oakland County as a pilot study.

53-79A Medical arbitration — one-time agreement.

This resolution directs MSMS to seek legislative changes in the Michigan Medical Arbitration Law to allow for one-time contractual agreement between the physician and his patient and to allow emergency patients to sign the arbitration agreement at the time of their registration in the emergency room. The resolution further directed MSMS to encourage the Michigan Hospital Association member hospitals to make special efforts to assist their patients to be more aware of the arbitration option.

The MSMS Arbitration Committee reports that Arthur Young and Company was hired by the Michigan Arbitration Advisory Committee to review and evaluate the arbitration program required to meet the several statutory requirements under the arbitration law. Because of the insufficient number of closed arbitration cases completed to date, the Arbitration Advisory Committee and the insurance bureau recommended to the legislature that the date of the creation of the joint legislative committee to review the operation and experience of arbitration be postponed until July 9, 1981, and the date for a report of recommendations for statutory changes by the joint committee to the entire legislature be postponed until July 9, 1982.

Further, the Arbitration Advisory Committee, acting upon the recommendations of MSMS and others, has embarked on a campaign to educate physicians, hospital personnel and the

public about the Michigan Arbitration Program. Posters have been placed in 235 hospitals; radio messages and TV commercials have been developed and released; and workshops have been conducted for employees of hospitals around the state to provide the patient with more information on the option of arbitration.

60-79A Governmental regulations affecting the cost of medical care.

This resolution directed The Council to identify the costs of various governmental factors in the nation's increased total medical costs and undertake a public relations program to place the responsibility for these increased costs where it belongs.

The results of a massive study of the components of the cost of health care undertaken by DHEW are scheduled to be released in the near future. Part of this study addresses itself to costs created within the system by government regulation. As soon as these results are released, they will be analyzed and any further work will be undertaken to provide data for inclusion in the public relations campaign called for in this resolution.

The resolution further directed the MSMS Delegation to the AMA to pursue this subject at the national level.

A resolution introduced at the AMA House of Delegates was referred by the AMA House to the AMA Board of Trustees.

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For tuition and advance registration information, call Spectrum Psychological Services, (313) 426-2334.

Physicians: participation in this program may be reported to the Michigan Board of Medicine for Category 2 credit of up to 10 hours for re-registration requirements. It may also be reported for Category 2 A.M.A. awards.

Saturday, April 26

9:00 am - 9:30 am Registration
9:30 am - 12:30 pm Core Concepts of Sex Therapy (Masters/Johnson)
Adolescent Sexuality (Kolodny)
Geriatric Sexuality (Masters)
2:00 pm - 5:00 pm Vaginismus (Biggs)
Impotence (Masters)
Anorgasmia (Johnson)

Sunday, April 27

9:30 am - 12:30 pm Disorders of Ejaculation (Masters/Biggs)
Drugs and Sex (Kolodny)
Sexual Aversion (Johnson)
2:00 pm - 4:15 pm Sex and Chronic Illness (Kolodny)
The Aftermath of Rape (Biggs)
Homosexuality in Perspective (Masters)



William H. Masters, M.D. & Virginia E. Johnson, D.Sc.



Robert C. Kolodny, M.D.



Mae A. Biggs, R.N., B.S.N., M.A.

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9:00 am - 5:00 pm each day — For tuition and advance registration information, call Spectrum Psychological Services, (313) 426-2334.

Physicians: participation in this program may be reported to the Michigan Board of Medicine for Category 2 credit. It may also be reported for Category 2 A.M.A. awards.

In addition to these programs, Spectrum Psychological Services sponsors a wide variety of workshops for mental health professionals, a Friday night lecture series in Ann Arbor, and ongoing training, treatment, and drug abuse counseling services. For information or referral assistance, call Spectrum Psychological Services, 6869 Marshall Rd. Dexter, Mich. 48130 (313) 426-2334.



Michigan's government and you, doctor

The Michigan Department of Management and Budget

By Sherry Nolte Wellman, MSMS Government Agency Liaison

Part four of a series to help Michigan physicians better understand the relationship of state government to medical practice.

State government's Department of Management and Budget has deep influence over Michigan physicians through several of its offices.

Public acts created the Department of Management and Budget in 1973, combining the former Department of Administration and the former Bureau of Programs and Budget of the executive office, including the Commission on Aging and the Office of Health and Medical Affairs. The director of the Department of Management and Budget (DMB), Gerald H. Miller, PhD, is appointed by the governor.

The department is organized into six major offices and six major bureaus.

The Office of Budget, Office of Revenue and Tax Analysis, Office of Health and Medical Affairs, and Office of Criminal Justice assist the Governor in formulating and executing program plans, policy analysis and production of the executive budget.

The Office of Intergovernmental Relations handles federal, regional and local government relations. In addition, an Office of State Employer develops executive branch policy on classified employee compensation and working conditions, and for consultation with employee organizations.

The Bureau of Special Boards and Commissions and the Office of Human

Resources Policy and Special Projects assist the special boards, commissions and councils assigned to the Department of Management and Budget, including the Office on Services to the Aging and the Council for the Arts.

The Bureau of Facilities administers the State's capital outlay program and maintains and operates state office and related facilities. The Bureau of Management Sciences recommends policies and provides management advice relating to the State's automatic data processing, telecommunications systems and management-consultant contracting. The Bureau of Management Services provides centralized accounting, purchasing, communications and transportation services to state agencies. The Bureau of Retirement Systems administers several state and some local public retirement systems. The Bureau of State Lottery administers the lottery and regulates bingo.

Office of Health and Medical Affairs — Jay G. Endsley, Director

Although OHMA has existed in various forms since the mid-1960's, it was in 1972 that the Office of Health and Medical Affairs came into its current form. Executive Order 1972-12 created the State Health Planning Advisory Council and the Office of Health and Medical Affairs (OHMA), and located both in the executive office. When budget and programs moved out of the executive office, both OHMA and the council were transferred to the Department of Management and Budget.

The executive order specified that OHMA would serve as the focal point for health advice to the Governor, including matters of policy, and that a state health plan should be developed encompassing both public and private health services, facilities and manpower to meet the physical, mental and environmental health needs of the people of Michigan. The major significance of the state health plan is that the executive order specified that upon its approval by the Governor it would serve as the principal guide to all agencies in the executive branch in developing health programs and policy.

In a structural and functional sense, Michigan's Office of Health and Medical Affairs was better prepared than other states' agencies when President Ford signed into law the National Health Planning and Resources Development Act (PL 93-641) in January of 1975.

This law created a new structure replacing comprehensive health planning, the Hill-Burton program, and the regional medical program. The act set up a single organization consisting of national, regional, state and areawide levels of health planning with specified functions for each.

The law required each state governor to identify a single state agency to serve as the state health planning and development agency, and OHMA was designated by Governor Milliken in October of 1975. The Governor also specified that a Statewide Health Coordinating Council be appointed to replace the existing advisory council.

(continued on page 164)

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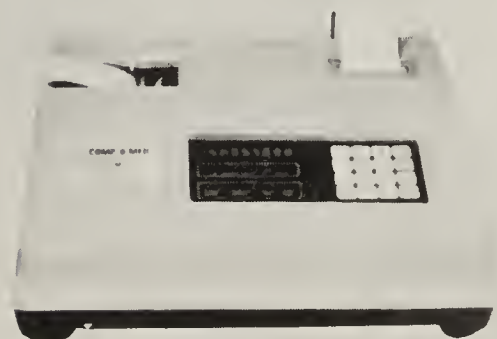
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MANAGEMENT AND BUDGET *continued*

Subsequently, legislation was introduced and passed which complemented the federal health planning law at the state level.

The Office of Health and Medical Affairs serves as staff to the Statewide Health Coordinating Council (SHCC) and is responsible for annual preparation of the preliminary state health plan and its implementation after adoption by the SHCC, the legislature and the governor.

In the areas of health planning, MSMS relates to OHMA in several ways.

The MSMS Steering Committee on Health Planning reviews and comments on the annual state health plan. The MSMS Physician/HSA Support Center works closely with physicians in the eight HSAs to provide medical contributions to regional health systems plans and bed reduction plans, both of which are coordinated with the SHCC and OHMA.

In addition to its health planning role, OHMA develops the executive office budget for the Medicaid program and the Michigan Department of Public Health. Budget and planning are linked here in two of the major health areas of the state. The MSMS Medicaid Liaison Committee which closely monitors the annual proposed budget recommendations for physician services under Medicaid, relates to OHMA in this regard.

As the focal point for health advice to the Governor, OHMA plays an influential role in the legislative arena. It analyzes health legislation and makes recommendations to the Governor to either support or oppose particular proposals.

The MSMS Department of Government Relations and the staff person for government agency liaison often work together with OHMA to secure legislation on a variety of issues.

Patients needed

Management of Phobias For Physical Objects

Subjects of the study are persons with simple phobias for physical objects of severity sufficient to warrant treatment which is provided free of charge for those cooperating in the study. The phobia must be for physical objects which can be transported without difficulty (small animals, insects, reptiles, or other physical objects of comparable size). Subjects must not have a serious physical illness, and must be able and willing to discontinue any and all medication (including oral contraceptives) during the course of the study. The study itself consists of four visits to the Clinical Research Center, each lasting about 3½ hours. Subjects need not stay overnight at the center. Visits can be scheduled at the mutual convenience of the subject, the investigators, and the CRC staff. Each visit will occur at the same time of day for any one subject and will usually be about one week apart. At the beginning of each visit, a small intravenous needle or catheter will be placed in the forearm vein so that blood samples may be drawn at 20 minute intervals without sticking the subject on each occasion. Between blood samplings, subjects will rest quietly in the CRC with the exception of the second hour of the second and third visit. During these times the phobia will be treated by the method known as *in vivo* exposure. This involves asking the subject to approach the feared object as closely as possible and remain as close as possible until the object is no longer feared. At the end of the experiment some subjects will also have completed treatment. Those who have not will be offered additional treatment free of charge until they have received the maximum benefit obtainable. The additional treatment sessions will be conducted in the phobia clinic rather than in the CRC and will not involve any further blood sampling. The blood samples will be assayed for the content of several hormones in order to determine the effect of the exposure therapy on the secretion of hormones thought to be affected by stress.

To apply for participation in the project, contact George C. Curtis, MD, Department of Psychiatry, University of Michigan Hospital, 1405 East Ann Street, Ann Arbor, Michigan 48109, Telephone 313-764-5348.

Experimental Management of Wilson's Disease

Patients with Wilson's Disease are required, so that we may initiate a clinical trial of a new treatment for the disease. This trial consists of oral zinc therapy. The rationale is based upon the competition of zinc and copper for gastrointestinal absorption sites, and on the observation that when oral zinc has been administered to other

types of patients according to a particular schedule, copper deficiency has been regularly produced. Thus, the idea suggests itself that a negative copper imbalance may be induced in Wilson's Disease by simple administration of oral zinc. Our studies are designed such that in the beginning, there is minimal interference with the patient's ongoing therapy, for instance with penicillamine. If zinc is established as effective, patient's treatment with penicillamine will be replaced in a very carefully controlled manner. Zinc treatment of Wilson's Disease would be very advantageous of course, because penicillamine is often very toxic. In initial studies, patients will be hospitalized for two 10 day periods about one month apart. All hospitalization and involved studies will be paid for, and transportation can be provided for the patients. Contact George J. Brewer, MD, Department of Human Genetics, University of Michigan Medical School, Ann Arbor, MI 48109, or call collect 313-764-5499.

Studies of Gout, Lesch-Nyhan Syndrome Glycogen Storage Disease Type I or Immunodeficiency Diseases

An active research and treatment program is currently underway for the diagnosis in therapy of disorders of purine metabolism in man. Patients are needed who fall into the following categories.

1. Hyperuricemia and gout. Studies are being carried out to understand more about the pathogenesis and effective treatment of these disorders.

2. Lesch-Nyhan Syndrome. This disorder includes juvenile hyperuricemia, self-mutilation, choreoathetosis and mental retardation. Studies are being carried out to evaluate the metabolic abnormalities in this disorder and experimental therapy is being attempted for the CNS disease.

3. Glycogen storage disease type I (glucose-6-phosphatase deficiency). Studies are underway to understand the basis for the hyperuricemia in this disorder.

4. Immunodeficiency diseases and purine enzyme defects. The diseases of interest include: severe combined immunodeficiency disease with adenosine deaminase deficiency, a disorder of cellular immunity with purine nucleoside phosphorylase deficiency, and hypogammaglobulinemia with 5'-nucleotidase deficiency. We are currently attempting to understand more about the basis for the association of these two types of disorders to discover the most effective therapy based on the abnormalities delineated.

Patients will be admitted to the Clinical Research Center at the University Hospital in Ann Arbor. The hospitalization costs for research studies will be paid for by the Clinical Research Center grant. Patients are expected to provide their own transportation.

For further information, please contact Irving H. Fox, MD, at the University of Michigan, 313/764-3240.

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Marquette-Alger County Society sponsors "Ask the Doctor" TV show

By William A. Mudge Jr., MD, Marquette



Relaxing before the WNMU-TV "Ask the Doctor" taping are, from left, the physician coordinator, Busharat Ahmad, MD; the show's moderator, George Wendt, Dan Arnold, MD, Don Elzinga, MD, and Douglas Sherk, MD.

Second of a series on component medical societies in Michigan.

"Ask The Doctor" in the Upper Peninsula is more than a pat phrase.

It also is the title of a prime time (7:30 to 8 p.m.) TV program aired once a month over WNMU-TV, Channel 13, a public educational television station. The show is beamed to the Upper Peninsula of Michigan and Northern Wisconsin and is in its fourth year of programming. Sponsor of the program is the Marquette-Alger County Medical Society.

Six toll-free telephones, manned by medical auxiliary members, receive the public's questions, which are "fed" to a moderator who, in turn, reads them to the panel of three physicians. A physician screens the questions before passing them on to the moderator.

During the 30 minute program, an average of 75 to 85 phone calls are received — making it impossible to answer all. Those left over are used to help get the program started the

Doctor Mudge is president-elect of the Marquette-Alger County Medical Society.

following month.

"Ask The Doctor" is the most popular of the UP shows of its type and represents one of a number of significant public service activities by the medical society and its auxiliary.

The first physician coordinator was Daniel Mazzuchi, MD, a Marquette nephrologist and now medical director of the Upper Peninsula Medical Education Program. The second and current coordinator is Busharat Ahmad, MD, Marquette ophthalmologist who is also a councilor to the Michigan State Medical Society.

To help defray production costs, the Marquette-Alger County Medical Society has sponsored the program for the first two seasons. Due to increased costs and considering the large coverage area, the MSMS has agreed to pay half the sponsoring costs for the remainder of this season's programming. According to Doctor Ahmad, "The partnership between MSMS and our local society in helping to sponsor these programs has fostered good relations between Northern Michigan University, the medical community, and the public."

Remaining "Ask the Doctors" programs are slated for Wednesday, March 19, April 16, May 21, and June 18.

The following paragraphs describe several more county medical society activities.

• Northern Michigan University has a relatively large number of pre-med students. A fund has been established by the auxiliary to underwrite travel expenses for those students seeking interviews at medical schools. The Marquette-Alger County Medical Society, with its 90 members, has recently added its financial support to the program. The auxiliary also has an emergency loan fund for pre-med students and students in the Michigan State University Modular Medical-Hospital Residency Program.

• The MAMS auxiliary recently made donations to a new local search and rescue squadron, and to the AMA Educational Research Fund. Money for the latter was raised when members donated amounts they would have spent on Christmas cards to society members.

• Marquette-Alger Society meetings topics have included "Financial Management and Trusts," "The Doctor and the Adolescent in the Family," and "Communication within the Professional Marriage."

MEETINGS



MSMS, MSMS/A, AMA and medical assistants

March 21 — MSRT Executive Council Meeting, PSG Conference Room, MSMS headquarters, contact: Caroline Rich, MSMS headquarters.

April 10 — MSMS Conference on Medical Aspects of Organized Athletics, Long's, Lansing, contact: Mert Scholten, MSMS headquarters.

April 17 — AMA 33rd National Conference on Rural Health, Sheraton-Boston, contact: Barbara Chapman 312/751-6604 or Gary Schwartz 312/751-6431.

April 17-19 — Annual Convention and House of Delegates, State of Michigan Branch, American Association of Medical Assistants, Hilton Inn at Plymouth, contact: Margaret Broadwell, 16686 East Eight Mile Rd., Detroit, 48205.

April 18-20 — Medical Assistants State Convention, Plymouth Hilton, Plymouth, contact: Caroline Rich, MSMS headquarters.

April 21 — MSMS Auxiliary Legislative Day, Kellogg Center, East Lansing, contact: Caroline Rich, MSMS headquarters.

April 24-26 — AMA 76th Congress on Medical Education, Palmer House, Chicago, contact: John Fauser, MD, AMA, 535 N. Dearborn St., Chicago, 60610.

April 25-27 — 1980 MSMS House of

Delegates, Michigan Inn, Southfield, contact: Richard Campau, MSMS headquarters.

May 5-7 — MSMS Auxiliary 54th Annual Convention, Weber Inn, Ann Arbor, contact: Caroline Rich, MSMS headquarters.

July 10-13 — MSMS Council, Holiday Inn, Marquette, contact: Warren Tryloff, MSMS headquarters.

Sept. 10 — MSMS Council, MSMS headquarters, contact: Warren Tryloff, MSMS headquarters.

Oct. 22 — MSMS Council, MSMS headquarters, contact: Warren Tryloff, MSMS headquarters.

Nov. 18-19-20 — 1980 MSMS Annual Scientific Meeting, Hyatt Regency Dearborn, contact: Sherry Fent, MSMS headquarters.

Dec. 3 — MSMS Council, MSMS headquarters, contact: Warren Tryloff, MSMS headquarters.

Other meetings

March 22-23, April 26-27, May 17-18 — Sexuality Training for Professionals, at Michigan League, Ann Arbor, contact: Michael Brown, 6869 Marshall Rd., Dexter, 48130, 313/426-2334.

April 7 — Wayne County Medical Society Beaumont Lecture, Henry Ford Hospital, contact: Roger Mecum, 1010 Antietam, Detroit, 48207, 313/963-1640.

May 1-2 — Annual Meeting and Resident Surgeons Day, Michigan Chapter, American College of Surgeons, at Detroit, contact: J. H. McLaughlin, MD, 604 N. Woodward, Birmingham, 48011.

May 2 — Annual Meeting, Michigan Society of Thoracic Surgeons, at Detroit, contact: Rodman E. Taber, MD, Michigan Society of Thoracic Surgeons, 30050 Hoover Rd., Warren, 48093.

May 7 — Executive Committee Meeting, Michigan Allergy Society, at Henry Ford Hospital, Detroit, contact: Benjamin Stone, MD, 1005 Abbott Rd., East Lansing, 48823.

May 21-23 — Michigan Hospital Association Medical Staff/Trustee/Administrator Forum, Boyne Mountain Lodge, contact: Michigan Hospital Association, 2213 E. Grand River Ave., Lansing, 48912.

May 29-31 — 1980 American Hospital Association National Conference on Trustees, Renaissance Center, Detroit, contact: American Hospital Association, 840 N. Lakeshore Dr., Chicago, IL 60611.

June 7-8 — Spring Symposium, Michigan Otolaryngological Society, at Bay Valley Inn, Bay City, contact: Dieter Wendling, MD, Macomb Ear, Nose and Throat Center, 14 Belleview, Mt. Clemens, 48043.

June 13-15 — Annual Meeting Michigan Dermatological Society, Bay Valley Inn, Bay City, contact: Alejandro Morales, MD, Dept. of Dermatology, Henry Ford Hospital, 2799 W. Grand Blvd., Detroit, 48202.

June 13-15 — Annual Meeting, Michigan Chapter, American College of Chest Physicians, at Boyne Highlands, Boyne City, contact: Susan Gibson, American Lung Association of Southeast Michigan, 28 W. Adams, Detroit, 48226, 313/961-1697.

June 26-27 — Michigan Hospital Association Annual Meeting, Grand Hotel, Mackinac Island, contact: Michigan Hospital Association, 2213 E. Grand River Ave., Lansing, 48912.

July 8-10 — Annual Scientific Meeting Michigan Chapter American Academy of Pediatrics, Bay Valley Inn, Bay City, contact: Miles Tiernan, 32245 Hearthstone, Farmington Hills, 48018, 313/553-3646.

CATEGORY I COURSES

Michigan Medicine each month carries a list of opportunities in Michigan for doctors of medicine to obtain Category I credit toward meeting the requirements of Michigan law. Sponsors of Category I programs and courses in Michigan are invited to submit information for the monthly calendar.

Each listing below, of programs that carry at least 3 hours of Category I credit, indicates a contact person, so the physician can obtain details. Physicians with questions about accredited programs may phone MSMS Headquarters, 517/337-1351.

The following have been accredited directly by the AMA or by MSMS CME Accrediting Committee. Physicians may wish to write to the hospitals and organizations that are accredited and ask to be placed on mailing lists for announcements about future programs.

Organizations:

American Association for Hand Surgery, Warren
American College of Emergency Physicians, Lansing
American College of Psychiatrists, Southfield
American Society of Colon and Rectal Surgeons, Detroit
American Society of Dermatopathology, Ann Arbor
Ann Arbor Psychiatric Association
Commission Professional and Hospital Activities, Ann Arbor
Michigan Academy of Family Physicians
Michigan Academy of Plastic Surgery
Michigan State Medical Society
Michigan State University College of Human Medicine, East Lansing
Michigan Chapter, American Academy of Pediatrics
Michigan Dermatological Society
Michigan Heart Association
Michigan Lung Association, Lansing
Michigan Ophthalmological Society
Michigan Psychoanalytic Society
Michigan Society of Anesthesiologists
Noah Worcester Dermatological Society, Detroit
Section of Gastroenterology, American Society for Gastroenterology, Detroit
University of Michigan Medical Center, Ann Arbor
University of Michigan School of Public Health
Wayne State University School of Medicine, Detroit

Hospitals:

Bay County Medical Education (Bay Medical Center, Bay Osteopathic Hospital, Bay City Samaritan Hospital)
William Beaumont Hospital, Royal Oak
Beyer Memorial Hospital, Ypsilanti
Blodgett Memorial Hospital, Grand Rapids
Bon Secours Hospital, Grosse Pointe
Burns Clinic Med. Center, PC/Northern Michigan Hospitals Inc., Petoskey
Butterworth Hospital, Grand Rapids
Central Michigan Community Hospital, Mt. Pleasant
Chippewa County War Memorial Hospital, Sault Ste. Marie

Community Health Center of Branch County, Coldwater
Community Hospital Association of Battle Creek
Cottage Hospital of Grosse Pointe
Detroit-Macomb Hospital Association
Dickinson County Memorial Hospital, Iron Mountain
Ferguson-Droste-Ferguson Hospital, Grand Rapids
Grace Hospital, Detroit
Gratiot Community Hospitals, Alma
Hawthorn Center, Northville
Henry Ford Hospital, Detroit
Heritage Hospital, Taylor
Holy Cross Hospital, Detroit
Hurley Medical Center, Flint
Ingham Medical Center, Lansing
Kalamazoo Regional Psychiatric Hospital
Lakeshore Continuing Medical Education, Inc. (Hackley Hospital and Mercy Hospital, Muskegon)
Leila Y. Post Montgomery Hospital, Battle Creek
Marquette General Hospital
McLaren General Hospital, Flint
Mecosta County General Hospital, Big Rapids
Mercy Hospital, Port Huron
Metropolitan Regional Psychiatric Hospital
Metropolitan Regional Psychiatric Hospital
Michigan Psychoanalytic Institute, Southfield
Midland Hospital Center
Mt. Carmel Mercy Hospital & Med. Center, Detroit
Munson Medical Center, Traverse City
North Detroit General Hospital, Detroit
Northville Regional Psychiatric Hospital
Oakwood Hospital, Dearborn
Orthopedic Guild, Inc., St. Joseph
Pennock Hospital, Hastings
Pontiac General Hospital, Pontiac
Portage View Hospital, Hancock
Port Huron Hospital CME Committee
Providence Hospital, Saginaw
Saginaw Cooperative Hospitals, Inc., Saginaw
Southwestern Michigan Area Health Education Center (Bronson Hospital and Borgess Hospital), Kalamazoo
St. Francis Hospital, Escanaba
St. John Hospital, Detroit
St. Joseph Hospital, Flint
St. Joseph Mercy Hospital, Pontiac
St. Joseph Mercy Hospital, Ann Arbor
St. Lawrence Hospital, Lansing
St. Mary's Hospital, Grand Rapids
St. Mary Hospital, Livonia
Sinai Hospital of Detroit, Detroit
Southwest Detroit Hospital
Edward Sparrow Hospital, Lansing
Traverse City Regional Psychiatric Hospital, Traverse City
V.A. Hospital, Battle Creek
West Shore Consortium, CME, Ludington/Hart/Manistee
Ypsilanti Regional Psychiatric Hospital, Ypsilanti

Date: March 15, **Genetic Disease in Clinical Practice.** **Location:** Education and Research Center, Henry Ford Hospital. **Sponsor:** Henry Ford Hospital. **For:** All interested physicians. **Cost:** \$70. **Contact:** Medical Education, Henry Ford Hospital, 2799 W. Grand Blvd., Detroit, (313) 876-1464. **Approved for:** 7 hours of Category I Credit.

Date: March 19-21, 1980, **Advances in Pediatrics.** **Location:** Towsley Center, Ann Arbor. **Sponsor:** U-M Office of Continuing Medical Education. **For:** All interested physicians. **Cost:** \$190. **Contact:** Towsley Center for CME, 313/764-2287. **Approved for:** 21 hours of Category I Credit.

Date: March 19, 1980, **Infectious Diseases in Obstetrics and Gynecology.** **Location:** Saint John Hospital. **Sponsor:** CME Committee of Saint John Hospital. **For:** All interested physicians. **Cost:** \$90. **Contact:** Ms. Linda Radu, Secretary, Continuing Medical Education, Department of Health Education, Saint John Hospital, 22101 Moross Road, Detroit 48236 (313/343-4000). **Approved for:** 8 hours of Category I Credit.

Date: March 20-21, **Advances in Pediatrics: Topics in Neurology and Endocrinology.** **Location:** Towsley Center, Ann Arbor. **Sponsor:** U-M Office of Continuing Medical Education. **For:** All interested physicians. **Cost:** \$120. **Contact:** Towsley Center for CME, 313/764-2287. **Approved for:** 13½ hours of Category I Credit.

Date: March 22, **Radiation Therapy in Everyday Clinical Practice.** **Location:** Education and Research Center, Henry Ford Hospital. **Sponsor:** Henry Ford Hospital. **For:** All interested physicians. **Cost:** \$55. **Contact:** Medical Education, Henry Ford Hospital, 2799 W. Grand Blvd., Detroit, 48202 (313) 876-1464. **Approved for:** 5½ hours of Category I Credit.

Date: March 23, **22nd Annual Spring Clinic.** **Location:** Valley View Restaurant, Shepherd. **Sponsor:** Central Michigan Community Hospital. **Co-Sponsor:** Gratiot Community Hospital. **For:** All interested physicians. **Contact:** Frank D. Johnson, MD, Central Michigan Community Hospital, 1221 South Drive, Mt. Pleasant, 48858. **Approved for:** 8 hours of Category I Credit.

Date: March 26, **Placental Pathology — Clinical Applications.** **Location:** Michigan Inn, Southfield. **Sponsor:** Michigan Society of Obstetricians and Gynecologists and Michigan Section, American College of Obstetricians and Gynecologists. **For:** Obstetricians and Gynecologists. **Contact:** Don R. Krohn, MD, Dept. of OB/GYN, Providence Hospital, Southfield, (313) 424-3000. **Approved for:** 7 hours of Category I Credit.

Date: March 26-28, 1980, **Urology Conference.** **Location:** Towsley Center, Ann Arbor. **Sponsor:** U-M Office of Continuing Medical Education. **For:** All interested physicians. **Cost:** \$175. **Contact:** Towsley Center for CME, 313/764-2287. **Approved for:** 21 hours of Category I Credit.

Date: March 27-April 2, 1980, **MAFP and SCAFP "Ails of Summer" Meeting.** **Location:** Kiawah Island, Charleston, SC. **Sponsor:** Michigan Academy of Family Physicians and South Carolina Academy of Family Physicians. **For:** Family physicians. **Cost:** \$100. **Contact:** Michigan Academy of Family Physicians, 416 North Homer, Suite #107, Lansing, MI 48912. **Approved for:** 25 hours of Category I Credit.

Date: March 29, **Alcoholism Conference.** **Location:** University of Michigan-Flint Center. **Sponsor:** Hurley Medical Center. **For:** All interested physicians. **Contact:** Richard D. Garlick, Hurley Medical Center, Sixth Ave. and Begole, Flint, 48502 313/766-0142. **Approved for:** 6 hours of Category I Credit.

(continued on page 170)



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CATEGORY I COURSES/continued

Date: March 29, 1980, **Gastroenterology for the Family Physician.** **Location:** Towsley Center, Ann Arbor. **Sponsor:** U-M Office of Continuing Medical Education. **For:** All interested physicians. **Contact:** Towsley Center for CME, 313/764-2287. **Approved for:** 7 hours of Category I Credit.

Date: April 10-11, **General Surgery.** **Location:** Towsley Center, Ann Arbor. **Sponsor:** U-M Office of Continuing Medical Education. **For:** All interested physicians. **Cost:** \$160. **Contact:** Towsley Center for CME, 313/764-2287. **Approved for:** 14 hours of Category I Credit.

Date: April 10-11, **Symposium on Gastrointestinal Hemorrhage.** **Location:** Towsley Center, Ann Arbor. **Sponsor:** U-M Office of Continuing Medical Education. **For:** General Surgeons, gastroenterologists, internists, family physicians and radiologists. **Cost:** \$190. **Contact:** Towsley Center, Office of CME, 313/764-2287. **Approved for:** 16 hours of Category I Credit.

Date: April 10-12, **Disease Prevention/Health Promotion.** **Location:** Hyatt Regency Dearborn. **Sponsor:** The departments of Family Medicine/Practice of Michigan State University, University of Michigan and Wayne State University. **For:** All interested physicians. **Contact:** Wayne State University School of Medicine, Division of Continuing Medical Education, 9B-32 Health Care Institute, Detroit 48201. **Approved for:** 10 hours of Category I Credit.

Date: April 11, **Perspectives in Pediatrics and Pediatric Surgery.** **Location:** Education and Research Center, Henry Ford Hospital. **Sponsor:** Henry Ford Hospital. **For:** Pediatricians. **Cost:** \$70. **Contact:** Medical Education, Henry Ford Hospital, 2799 W. Grand Blvd., Detroit 48202 (313/876-1464). **Approved for:** 8 hours of Category I Credit.

Date: April 11-13, **Morphogenesis and Pattern Formation. Implications for Normal and Abnormal Development.** **Location:** Towsley Center, Ann Arbor. **Sponsor:** U-M Office of Continuing Medical Education. **For:** All interested physicians. **Cost:** \$150. **Contact:** Towsley Center for CME, 313/764-2287. **Approved for:** 16½ hours of Category I Credit.

Date: April 12, **Premature Ruptured Membrane and Neonatal Outcome.** **Location:** Hurley Medical Center, Merliss Brown Auditorium. **Sponsor:** Hurley Medical Center. **For:** All interested physicians. **Contact:** Richard D. Garlick, Hurley Medical Center, Sixth Ave. and Begole, Flint 48502 313/766-0142. **Approved for:** 4 hours of Category I Credit.

Date: April 14-18, **Family Practice Review.** **Location:** Towsley Center, Ann Arbor. **Sponsor:** U-M Office of Continuing Medical Education. **For:** All interested physicians. **Cost:** \$275. **Contact:** Towsley Center for CME, 313/764-2287. **Approved for:** 33 hours of Category I Credit.

Date: April 18, **Fifth Annual Cardiac Rehabilitation Symposium.** **Location:** Borgess Medical Center Auditorium, Kalamazoo. **Sponsor:** Borgess Medical Center, Cardiac Rehabilitation Center. **Co-Sponsor:** Michigan Heart Association and American Academy of Family Physicians. **For:** All interested physicians, nurses and physical educators concerned with Cardiac Rehabilitation. **Cost:** \$50. **Contact:** E. Enrique Leguizamon, MD, Medical Director, CRI, Borgess Medical Center, 1521 Gull Rd., Kalamazoo 49001 616/383-8340. **Approved for:** 7 hours of Category I Credit.

Date: April 19, **Violence In The Family.** **Location:** Education and Research Center, Henry Ford Hospital, Detroit. **Sponsor:** Henry Ford Hospital. **For:** All interested physicians. **Cost:**

\$70. **Contact:** Medical Education, Henry Ford Hospital, 2799 W. Grand Blvd., Detroit 48202 313/876-1464. **Approved for:** 7 hours of Category I Credit.

Date: April 23, **Common Dermatological Diseases.** **Location:** Sheraton Inn, Kalamazoo. **Sponsor:** Southwestern Michigan Area Health Education Center. **For:** All interested physicians. **Cost:** \$50. **Contact:** Charles L. Zeller, Jr., MD, 252 East Lovell, Kalamazoo 49007 (616) 383-6360. **Approved for:** 8 hours of Category I Credit.

Date: April 23-25, **Hematology Review.** **Location:** Towsley Center, Ann Arbor. **Sponsor:** U-M Office of Continuing Medical Education. **For:** Hematologists, Medical Technologists. **Cost:** \$190. **Contact:** Towsley Center for CME, 313/764-2287. **Approved for:** 24 hours of Category I Credit.

Date: April 28-30, **Ob-Gyn Conference.** **Location:** Towsley Center, Ann Arbor. **Sponsor:** U-M Office of Continuing Medical Education. **For:** All interested physicians. **Cost:** \$175. **Contact:** Towsley Center for CME, 313/764-2287. **Approved for:** 21 hours of Category I Credit.

Date: April 30, **Pulmonary Medicine Update.** **Location:** Hurley Medical Center, Merliss Brown Auditorium. **Sponsor:** Hurley Medical Center. **For:** All interested physicians. **Contact:** Richard D. Garlick, Hurley Medical Center, Sixth Ave. and Begole, Flint 48502 313/766-0142. **Approved for:** 6 hours of Category I Credit.

Date: April 30, **Hypertension: Evaluation and Treatment.** **Location:** Towsley Center, Ann Arbor. **Sponsor:** U-M Office of Continuing Medical Education. **For:** All interested physicians. **Cost:** \$65. **Contact:** Towsley Center for CME, 313/764-2287. **Approved for:** 7 hours of Category I Credit.

Date: May 1-3, **Medicolegal Investigation of Death.** **Location:** Plaza Hotel, Renaissance Center, Detroit. **Sponsor:** Michigan Medical-Legal Research and Educational Association, Wayne County Medical Examiner's Office and Wayne State University School of Medicine. **For:** Emergency room physicians, medical examiners, coroners and pathologists involved in medico-legal work. **Cost:** \$150. **Contact:** Elaine M. Sacra, Office of Medical Examiner of Wayne County, 400 East Lafayette, Detroit 48226. **Approved for:** 15½ hours of Category I Credit.

Date: May 2-3, 1980, **Nuclear Radiology Workshop.** **Location:** Towsley Center, Ann Arbor. **Sponsor:** U-M Office of Continuing Medical Education. **For:** All interested physicians. **Cost:** \$150. **Contact:** Floyd C. Pennington, Director, Office of Continuing Medical Education, Towsley Center, University of Michigan Medical School, Ann Arbor 48109. **Approved for:** 16 hours of Category I Credit.

Date: May 8-9, **Ophthalmology Conference.** **Location:** Towsley Center, University of Michigan. **Sponsor:** U-M Office of Continuing Medical Education. **For:** Ophthalmologists. **Cost:** \$160. **Contact:** Towsley Center for CME, 313/764-2287. **Approved for:** 16 hours of Category I Credit.

Date: May 9, **Oto Clinical Conference.** **Location:** Towsley Center, University of Michigan. **Sponsor:** U-M Office of Continuing Medical Education. **For:** All interested physicians. **Cost:** \$25. **Contact:** Towsley Center for CME, 313/764-2287. **Approved for:** 5½ hours of Category I Credit.

Date: May 10, **Pulmonary Pathology and Transbronchial Biopsy.** **Location:** Borgess Hospital, Kalamazoo. **Sponsor:** Michigan Society of Pathologists. **For:** Pathologists. **Contact:** T. A. Reyman, MD, Department of Pathology, Mt. Carmel Mercy Hospital, 6071 W. Outer Dr., Detroit 48202. **Approved for:** 3 hours of Category I Credit.

Date: May 12-16, **Head and Neck Oncology.** **Location:** Towsley Center, University of Michigan. **Sponsor:** U-M Office of Continuing Medical Education. **For:** All interested physicians. **Cost:** \$500. **Contact:** Towsley Center for CME, 313/764-2287. **Approved for:** 42½ hours of Category I Credit.

Date: May 17, **Regional Oncology Symposium.** **Location:** General Motors Institute, Flint. **Sponsor:** Hurley Medical Center. **For:** All interested physicians. **Contact:** Richard D. Garlick, Hurley Medical Center, Sixth Ave. and Begole, Flint 48502 313/766-0142. **Approved for:** 6 hours of Category I Credit.

Date: May 19-23, **Advances in Internal Medicine.** **Location:** Towsley Center, U-M. **Sponsor:** U-M Office of Continuing Medical Education. **Cost:** \$290. **Contact:** Towsley Center for CME, 313/764-2287. **Approved for:** 35 hours of Category I Credit.

Date: May 21, 1980, **Medical Therapy in Family Practice.** **Location:** Saint John Hospital. **Sponsor:** CME Committee of Saint John Hospital. **For:** All interested physicians. **Cost:** \$90. **Contact:** Ms. Linda Radu, Secretary, Continuing Medical Education, Department of Health Education, Saint John Hospital, 22101 Moross Road, Detroit 48236 (313/343-4000). **Approved for:** 8 hours of Category I Credit.

Date: June 5-6, **Michigan Occupational Medical Association Annual Meeting.** **Location:** Bay Valley Inn, Bay City. **Sponsor:** Michigan Occupational Medical Association. **For:** All interested physicians. **Contact:** Joann Madden, 313/766-3252. **Approved for:** 4 hours of Category I Credit.

Date: July 25-27, 1980, **EKG Interpretation and Arrhythmia Management.** **Location:** Grand Hotel, Mackinac Island. **Sponsor:** International Medical Education Corporation. **For:** All interested physicians. **Cost:** \$215.00. **Contact:** International Medical Education Corporation, Division of Postgraduate Education, Dept. 12, 64 Inverness Drive East, Englewood, CO 80112 (800) 525-8646 Toll Free or (313) 773-1144. **Approved for:** 15 hours of Category I Credit.

Date: July 31-Aug. 3, **Michigan Ophthalmological Society Twelfth Annual Summer Conference.** **Location:** Grand Hotel, Mackinac Island. **Sponsor:** Michigan Ophthalmological Society. **For:** Ophthalmologists. **Cost:** \$75. **Contact:** Tanya Miller, MSMS headquarters, 517-337-1351. **Approved for:** 7 hours of Category I Credit.

Date: Oct. 15, **Pediatrics Infections.** **Location:** Hurley Medical Center, Merliss Brown Auditorium. **Sponsor:** Hurley Medical Center. **For:** All interested physicians. **Contact:** Richard D. Garlick, Hurley Medical Center, Sixth Ave. and Begole, Flint, 48502 313/766-0142. **Approved for:** 6 hours Category I Credit.

RURAL HEALTH CARE/ UPDATE 1980



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DEATHS



Bradley M. Harris, MD Ypsilanti

Bradley Harris, MD, former MSMS president, died Dec. 23 at the age of 74. Doctor Harris was MSMS president in 1967-68, was a former MSMS councilor and had served on numerous MSMS committees. He also was a former chairman of the MSMS Committee on Publications.

In 1931, Doctor Harris earned his MD from the University of Michigan. He took his residency in Boston, Toledo, and Grand Rapids, before beginning his practice in Ypsilanti in 1934.

Doctor Harris' community activities included the Boy Scouts, the Ypsilanti Players, the Industrial Development Council, and election to the post of coroner.

He served as president of the Ypsilanti Area Sesquicentennial Inc., the Ypsilanti Historical Society, the Ypsilanti Area Chamber of Commerce, and the Washtenaw County Medical Society.

He served on the boards of directors for the Ypsilanti Boys Club, the Michigan United Fund, Michigan Blue Cross Blue Shield and the National Bank of Ypsilanti. He also was a member of the Michigan State Board of Registration in Medicine.

Charles L. Callaway, MD Grand Rapids

Charles L. Callaway, MD, Grand Rapids, died Jan. 5 at the age of 44. Doctor Callaway was director of the Kent Oaks Hospital psychiatric department from 1967 to 1970. He received his MD from the University of Colorado in 1962. Doctor Callaway had served on the staffs of Blodgett Memorial Medical Center, Forest View Psychiatric Hospital and Butterworth Hospital.

W. Alan Chickering, MD St. Joseph

W. Alan Chickering, MD, St. Joseph, died Jan. 12. He was 60. Doctor Chickering was formerly chief of staff at Mercy Hospital in Benton Harbor and formerly president of the Berrien County Medical Society. At the time of his death he was secretary-treasurer of the Southwestern Michigan Academy of Medicine. Doctor Chickering earned his MD from Duke University in North Carolina.

Edward J. Hill, MD Detroit

Edward J. Hill, MD, Detroit, died Jan. 28 at the age of 62. Doctor Hill earned his MD from Western Reserve Medical School in Ohio. At the time of his death he was associated with Harper, Jennings and Children's hospitals.

Morton Levitt, PhD Davis, CA

Morton Levitt, PhD, Davis, CA, died Jan. 13 at the age of 59. Doctor Levitt had his undergraduate education in psychology at Wayne State University in Detroit and completed the requirements for his PhD in clinical psychology at the University of Michigan in 1955. In 1957 he was named assistant dean for student affairs and admissions in the School of Medicine at Wayne State University. In 1963 Doctor Levitt was named WSU associate dean for academic affairs. He held this position until 1970 when he was recruited to the Davis campus and was appointed associate dean for academic affairs and professor of psychiatry in the School of Medicine.

Darnell Mitchell, MD Detroit

Darnell Mitchell, MD, Detroit, died Jan. 13. He was 72. Doctor Mitchell was radiologist in-charge at Southwest General Hospital in Detroit and served on the board of directors of Broadstreet Medical Inc. In 1933 Doctor Mitchell received his MD from Meharry Medical College in Nashville.

Robert B. Sweet, MD Ann Arbor

Robert B. Sweet, MD, Ann Arbor, died Jan. 28 at the age of 63. He was professor and former chairman of anesthesiology at the University of Michigan. Doctor Sweet also was chief of anesthesiology at Veterans Administration Hospital since 1976. During his years with the University, Doctor Sweet established the first resident physician training in anesthesiology at the U-M. He also researched the effects of halothane, an anesthetic gas and was nationally recognized for making the first report on the possible liver toxicity of the substance.

CLASSIFIED

The rate for each classified advertisement in *Michigan Medicine* is 15¢ per word, with a minimum charge of \$7.50. Copy for classified advertisements should be received not later than the first of the month preceding the month of publication.

Positions open

Part-Time Physician Needed to do routine physicals to assess donor suitability for plasmapheresis. Good job for older physician looking to slow down. Malpractice coverage provided. Contact Doug Klynstra or Debra White at American Plasma Management, East Lansing. Phone 517-351-2620.

Internist with interest in cardiology, to join long established practice in rural community within 30 miles of large shopping areas. Active coronary care unit, excellent hospital and office facilities. Opportunity to become rapidly established in a busy practice with no investment. All Corporation fringes. Please call Area Code 517-846-6122 days or 846-4620 evenings, or write Malcolm K. Dolbee, MD, P.C., P.O. Box 609, Standish, Michigan 48658.

Thinking of Retiring? Any age physician, medical directorships available across the USA. List valid licenses, when able to relocate. Salary \$30,000.00 per year, 35 hours per week, malpractice insurance paid. If physician is not retired and desires a new practice opportunity, please send curriculum vitae, site location, salary, date able to relocate. Write: Fred Hrachovina, DO, 1000 Second Ave., South Minneapolis, Minnesota 55403 or call: 612-332-7938.

Position Available — Medical Director for Hospice of Southeastern Michigan located in Southfield. Must be a physician employed "whole time" by the hospice with knowledge of pain management and ability to coordinate other area professionals with pain management expertise. Forty-bed inpatient unit with home care program. Salary negotiable. Send resume by March 1, 1980 to Mrs. Peg O. McCuiston, Hospice of Southeastern Michigan, 22401 Foster Winter Drive, Southfield, Michigan 48075.

Multi Specialty Clinic in Northern Michigan recruiting for following Specialties: Internal Medicine, Family Practice, Urology, Orthopedics, Ophthalmology, Obstetrics & Gynecology. Excellent opportunity with exceptional first year guarantee — will negotiate. Contact: Jo Brower, Emergency Consultants Inc., One Windemere Place, Petoskey, MI 49770. (616) 347-1580. Out-of-state, (800) 253-7092.

Family Practitioners: To expand central core of primary care physicians in well established southeastern Wisconsin multi-specialty clinic. 30 miles from Milwaukee. Excellent recreation area. \$45,000 first year salary, with additional incentive plan and many other fringe benefits. Excellent opportunity. Send CV to Recruitment Committee, Burlington Clinic, S.C., Box 40, Burlington, WI 53105.

Urologist Position available at progressive VA Medical Center located in Michigan's upper peninsula. Board certified candidates are preferred. The community offers ideal family living in town of 18,000 people with good schools, year-round sportman's area with excellent hunting, fishing and winter sports. Well equipped 214-bed GM&S medical cen-

ter offering competitive salary and benefits. Applicants must meet required spoken and written English proficiency. Write: Chief of Staff, VA Medical Center, Iron Mountain, MI 49801 or call: (906) 774-3300, Ext. 227. Allowable moving expenses paid. Equal opportunity employer.

Physicians — Metropolitan Regional Psychiatric Hospital has assumed the administration of the Reuther Long Term Care Facility in Westland, Michigan. Several full-time and part-time positions have been established in the classification of Physician. The starting salary will be in the range of \$19.66-\$24.59 hourly, depending on qualifications and experience. A complete range of Michigan Civil Service benefits is available. Preference will be given to candidates who specialize in either internal medicine or family practice. Contact Raman Bhavsar, MD, Chief of Clinical Affairs at (313) 722-7030, extension 6606 to arrange an interview.

Student Oriented Health Service serving 7,500 technical student population seeks primary care physician. Outpatient clinic, shared call. Liberal fringes, competitive wage. Contact: J. L. Anderson, MD, Director, MTU Health Service, Houghton, MI 49931, or call 906-487-2435. Michigan Technological University is an Equal Opportunity Educational Institution/Equal Opportunity Employer.

General/Family Practice Physician. For group of five clinics in Detroit innercity and suburbs. Plenty of professional freedom. Hours 10 a.m. to 6 p.m. with hospital optional. Malpractice, medical, dental, life and disability insurance paid, also auto allowance. Trail Clinics, 16840 E. Warren, Detroit. (313) 882-7060 Cindy Thompson.

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Marquette, Michigan. Urologist needed immediately or in the near future to replace urologist in a two man practice. Marquette is a university community on the unspoiled south shore of Lake Superior. Admitting privileges at Marquette General Hospital offering regional medical care for people in the central area of the Upper Peninsula. 18 bed urologic unit, fully equipped hospital with advanced lab facilities; ultrasound, CT scanner; excellent radiologic service. Hospital has a young and excellently trained nephrologist; active cardiovascular surgery service. Current staff of 79 solo and a small group of private practice practitioners. 87% board certified, average age of active staff is 42 years. Please contact: John D. Wojcik, MD, Marquette General Hospital, 420 West Magnetic Street, Marquette, Michigan 49855. Phone: 906-228-9440.

Emergency Medicine Positions: available with Emergency Physician Group throughout Michigan, PA, NY, NJ, and Southeastern U.S. including all suburban, rural and metropolitan areas. Fee-for-services with minimum guarantee provided. Malpractice paid. Practice credits toward board certification. Please send resume to: NEEMA Emergency Medical, Ste. 400, 399 Market St., Philadelphia, PA 19106. In Pennsylvania, call 215-925-3511, those outside Pennsylvania call 1-800-523-0776.

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PRESIDENT'S PAGE

The time is past for excuses not to join, support MDPAC

By Ernest P. Griffin, Jr., MD, MSMS President

How often have you asked, "What is the Congress or the State Legislature trying to do to the medical profession?"

This is a common question and more often a common complaint among physicians. For decades a "consumerist trend" has been developing, driven by consumers' attitude that they understand the delivery of quality health care better than practitioners do. This trend has the support of major sections of our society who put forth a sizeable commitment of time, energy and money to make sure this attitude is expressed through legislation and politics. Medicine must do the same.

Medical political support, however, cannot be made through the dues we pay to Michigan State Medical Society.

State and federal laws prohibit MSMS from making direct political contributions to candidates who support the principles of quality medicine.

Certainly, the legislative and lobbying efforts of the medical society have protected our interests; but with the ever-growing consumerist attitude, we must supplement these activities by offering financial and personal support to legislators who express our fundamental principles on the floor of the state legislature and Congress.

I was greatly encouraged to read the series of articles in the

February issue of *Michigan Medicine* regarding the activities of the Michigan Doctors Political Action Committee. I was, however, greatly discouraged to learn that MDPAC has the financial support of little more than 30 percent of the members of MSMS.

I find it difficult to comprehend how an organization like MDPAC in concept has the support of the overwhelming majority of Michigan physicians and yet, when it comes to actively contributing to its efforts, suffers a dramatic drop in support.

Physicians lodge several justifications to avoid contribution to the political action efforts of the medical profession:

1. Politics are dirty — medicine should remain above such endeavors.

2. I'm too busy with my practice to take on another activity.

3. I can barely afford to make ends meet now, and a \$50 or \$150 contribution is just too much.

I think these arguments just don't hold water. Politics are the basis of our society, and the reason our profession faces these repeated legislative and bureaucratic challenges. If we want to see our profession survive in the free market, we have to get down in the political gutter and fight the battles with those who hold our same basic principles.

The argument that a physician is too busy with practice to get involved is unjustified. MDPAC offers our profession the opportunity of a collective effort. Organization, information and expertise are the key to successful campaigns. Your political action committee offers all three.

As for money, members of the UAW political action committee contribute in excess of \$100 a year for the union's political activities. I'm confident physicians can match that amount.

The time for excuses is over. Medicine faces serious challenges in the next decade. I don't think there are many members of the Michigan State Medical Society who have a good enough reason not to join the Michigan Doctors Political Action Committee.

I strongly urge you to send your regular contribution of \$50 or join me in becoming a sustaining member, with a \$150 contribution to MDPAC, PO Box 769, East Lansing, Michigan 48823.

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BactrimTM DS Double Strength Tablets

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Just one tablet b.i.d. for 10 to 14 days



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- Convenient *b.i.d.* dosage provides day-and-night antibacterial control
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Indications and Usage: For the treatment of urinary tract infections due to susceptible strains of the following organisms: *Escherichia coli*, *Klebsiella-Enterobacter*, *Proteus mirabilis*, *Proteus vulgaris*, *Proteus morganii*. It is recommended that initial episodes of uncomplicated urinary tract infections be treated with a single effective antibacterial agent rather than the combination. Note: The increasing frequency of resistant organisms limits the usefulness of all antibacterials, especially in these urinary tract infections.

Also for the treatment of documented *Pneumocystis carinii* pneumonitis. To date, this drug has been tested only in patients 9 months to 16 years of age who were immunosuppressed by cancer therapy.

The recommended quantitative disc susceptibility method (*Federal Register*, 37:20527-20529, 1972) may be used to estimate bacterial susceptibility to Bactrim. A laboratory report of "Susceptible to trimethoprim-sulfamethoxazole" indicates an infection likely to respond to Bactrim therapy. If infection is confined to the urine, "Intermediate susceptibility" also indicates a likely response. "Resistant" indicates that response is unlikely.

Contraindications: Hypersensitivity to trimethoprim or sulfonamides; pregnancy; nursing mothers; infants less than two months of age.

Warnings: Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia with purpura in elderly patients on certain diuretics, primarily thiazides. Sore throat, fever, pallor, purpura or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended; therapy should be discontinued if a significantly reduced count of any formed blood element is noted.

Precautions: Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function.

Adverse Reactions: All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. **Blood dyscrasias:** Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. **Allergic reactions:** Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. **Gastrointestinal reactions:** Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea and pancreatitis. **CNS reactions:** Headache,

peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. **Miscellaneous reactions:** Drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L. E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.

Dosage: Not recommended for infants less than two months of age.

Urinary Tract Infections: Usual adult dosage—1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 10-14 days.

Recommended dosage for children—8 mg/kg trimethoprim and 40 mg/kg sulfamethoxazole per 24 hours, in two divided doses for 10 days. A guide follows:

Children two months of age or older

Weight		Dose—every 12 hours	
lbs	kgs	Teaspoonfuls	Tablets
20	9	1 teasp. (5 ml)	½ tablet
40	18	2 teasp. (10 ml)	1 tablet
60	27	3 teasp. (15 ml)	1½ tablets
80	36	4 teasp. (20 ml)	2 tablets or 1 DS tablet

For patients with renal impairment:

Creatinine Clearance (ml/min)	Recommended Dosage Regimen
Above 30	Usual standard regimen
15-30	½ the usual regimen
Below 15	Use not recommended

***Pneumocystis carinii* pneumonitis:** Recommended dosage: 20 mg/kg trimethoprim and 100 mg/kg sulfamethoxazole per 24 hours in equal doses every 6 hours for 14 days. See complete product information for suggested children's dosage table.

Supplied: Double Strength (DS) tablets, each containing 160 mg trimethoprim and 800 mg sulfamethoxazole, bottles of 100; Tel-E-Dose® packages of 100. Tablets, each containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 40, available singly and in trays of 10. Oral suspension, containing in each teaspoonful (5 ml) the equivalent of 40 mg trimethoprim and 200 mg sulfamethoxazole, fruit-licorice flavored—bottles of 16 oz (1 pint).

ROCHE

Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

Please see back cover.

Her next attack of cystitis may require
the BactrimTM
3-system counterattack



ROCHE

Bactrim has shown high clinical effectiveness in recurrent cystitis as a result of its wide spectrum and distinctive antimicrobial action in the urinary, vaginal and lower intestinal tracts.

The probability of recurrent urinary tract infection appears to be enhanced by the establishment of large numbers of *E. coli* or other urinary pathogens on the vaginal introitus. The trimethoprim component of

Bactrim diffuses into vaginal fluid in effective concentrations, thus combating migration of pathogens into the urethra.

Studies have shown that Bactrim acts against *Enterobacteriaceae* in the bowel without the emergence of resistant organisms. Thus, Bactrim reduces the risk of introital colonization by fecal uropathogens. It has *no* significant effect on other normal, necessary intestinal flora.

**Bactrim fights uropathogens in the
urinary tract/vaginal tract/lower intestinal tract**

APR 18 1980

MICHIGAN MEDICINE

Vol. 79, No. 9
March 28, 1980

Breaking News for Michigan Doctors

MEDIGRAM

CAPSULES

MSMS IS BEGINNING WORK on materials to help Michigan physicians care for Indochinese refugees. With predictions that several thousand refugees are scheduled for resettling in the state, an MSMS task force is preparing to assist in the Asians' health care here. The task force is led by Hector Inchaustegui, MD, Royal Oak.

IMPORTANT DETAILS of the new Blue Cross Blue Shield of Michigan reimbursement system are scheduled for printing in the May issue of Michigan Medicine. BCBSM also is contacting Michigan physicians to describe changes in the reimbursement system. Further information is available from John Richards at MSMS headquarters.

MSMS LANGUAGE defining per case participation was inserted in HB 4555 (BCBSM reform) by the Senate Commerce Committee as the committee began work on a substitute to the House version of the bill. Until the new clause was accepted by the committee, there was doubt as to whether per case claims were covered. The committee adopted the BCBSM-preferred substitute, and set to work reviewing it line-by-line. The MSMS amendment defines a "participating contract" as "either a full participating contract or separate and individual contracts on a per claim basis as set forth in the provider class plan." The bill calls for a reimbursement plan for each class of providers.

Legislators seek slowdown in bed reduction plans

The state's criteria and guidelines for bed reduction were disapproved March 25 by the Joint Committee on Administrative Rules of the Michigan Legislature during their annual review. The legal effect of this disapproval on the bed reduction process was still being debated at press time, because the legislation is not clear on this point. Although it seems this disapproval does not affect the bed reduction plans that have already been written, the unanimous vote for disapproval is a clear statement of legislative concern about the bed reduction program. The criteria and guidelines are to be resubmitted to the committee after the new legislative oversight committee created by HCR 578 has had an opportunity to review the problem.

HCR 578 was introduced by Rep. Brotherton, and creates the legislative oversight committee for the bed reduction process in southeast Michigan. It also calls for a three-month moratorium on the implementation of the bed reduction program. Although a resolution does not have the authority to change a state law, it is a strong statement from the entire legislature that the bed reduction process should be slowed down to permit careful scrutiny.

The legislature's request for a moratorium is consistent with a call for a moratorium passed by the MSMS Council at its March 5 meeting and announced by MSMS President-Elect John R. Ylvisaker, MD, at a public hearing March 14 held by the Comprehensive Health Planning Council of Southeast Michigan. MSMS was joined in testifying against the bed reduction plans by the Wayne County Medical Society, Detroit Medical Society, Seven-County Physicians Health Planning Advisory Committee, and the Michigan Society of Obstetricians and Gynecologists. MSMS held a news conference and arranged television interviews to further emphasize the point.

**Inside! Last chance to register
for MSMS Sports Medicine Conference
April 10 in Lansing!**

EXAMPLES OF MEDICAL-LEGAL problems and questions encountered by Michigan physicians in their practice are sought by a new project group sponsored by the Michigan Medical School Council of Deans. Physicians are asked to send medical-legal questions and problems to the project group, which is preparing materials to teach law and medicine to physicians. The project is particularly interested in the specialties of obstetrics/gynecology and anesthesiology. Please submit questions and problems to Michigan Medical School Council of Deans, Medical-Legal Project, 527 E. Liberty St., Suite 205, Ann Arbor, 48109.

AS OF MARCH 1, the MSMS created Michigan Physicians Mutual Liability Company no longer requires the purchase of surplus certificates to obtain professional liability insurance. This action, taken by the MPMLC board of directors, seeks to attract physicians who may have been deterred from applying for coverage in the past by the \$2,000 cost of a surplus certificate. This action is the first step toward completely eliminating MPMLC surplus certificates. MPMLC will begin to redeem all certificates, in accordance with the MPMLC prospectus, within the next few years. In other developments, MPMLC now is offering limits of liability up to \$1 million per occurrence/\$1 million annual aggregate. MPMLC is the first company in several years to make this option available to Michigan physicians.

MSMS Committee on State Legislation seeks MSMS members' evaluation

Advice and observations from the membership are being solicited by an ad hoc task force of the MSMS Committee on State Legislation and Regulations charged with a periodic review of MSMS government relations programming and effectiveness. Thomas E. Stone, MD, a member of the Committee on State Legislation and Regulations for 10 years, is chairman of the study group and has issued a call for comments by members to assist his committee's work. Doctor Stone also plans an open meeting April 17 in the MSMS building for discussion of MSMS government relations programs. W. E. Maldonado, MD, chairman of the standing committee on legislation, told Doctor Stone, when appointing the committee, "This must not be regarded as criticism of existing programs. We're simply reviewing in the most constructive sense. Government is changing rapidly in Lansing as in Washington, and constant review of how we function is vital. I am asking you to conduct such a review only to answer the question, 'Can we do it better?'" Members of the study group are Doctor Stone, Doctor Maldonado, Robert D. Burton, MD, Grand Rapids; Richard Heuschele, MD, Saginaw; James A. Read, MD, Pontiac; Thomas R. Berglund, MD, Kalamazoo; and President Ernest P. Griffin, Jr., MD, Flint; President-Elect John R. Ylvisaker, MD, Pontiac, and Vice Speaker David Siegel, MD, Lansing.

MSMS hears of Medicaid plight

On March 18 the MSMS Medicaid Liaison Committee received details on the State's fiscal condition and the implications for Medicaid. The state estimates a supplemental appropriation of at least \$118 million will be required to fund Medicaid for the remainder of the 1979-80 fiscal year. The economic picture for the 1980-81 budget is even more severe given the State's unemployment rate, an explosion in the welfare case load, and decisions at the federal level to cut state revenue sharing. These are the reasons, the MSMS committee heard, why physician fee screens have yet to be updated for the current fiscal year.

1980 Conference on Sports Medicine

**Thursday, April 10, 1980
Long's Convention Center
Lansing**

Sponsored by Michigan State Medical Society

The Michigan State Medical Society will grant 6 hours of Category I continuing medical education credit toward the state requirements. AAFP prescribed credits for family physicians also will be awarded.



- 8 a.m. Registration and coffee
- 9 a.m. Welcome: Edwin R. Guise, MD, conference chairman
- 9:05 a.m. "Women in Athletics"
Rose Snyder, ATC, Athletic Medicine Institute, Henry Ford Hospital
- 9:45 a.m. "Swimmer's Shoulder"
Jerome Ciullo, MD, Dept. of Orthopedic Surgery, Henry Ford Hospital
- 10:25 a.m. Coffee Break
- 10:40 a.m. "Tennis — The Fun; The Problems"
Neal Marcus, MD, Dept. of Orthopedic Surgery, Henry Ford Hospital
- 11:15 a.m. "Medical Problems of Competitive Runners and Garden Variety Joggers"
Robert Teitge, MD, Stanford University Sports Medicine Clinic, Palo Alto, CA
- 12:15 p.m. Luncheon
Charles Zimont, MD, chairman, MSMS Sports Medicine Committee, Presiding
- 1:30 p.m. "Prevention, Protection and Recognition of Head and Neck Injuries"
Joseph Godfrey, MD, Orthopedic Surgeon, Buffalo, NY (former team physician for Buffalo Bills)
- 2:10 p.m. "Rehabilitation in High School Athletics"
Lou Meeks, MD, Orthopedic Surgeon, Ypsilanti
- 2:50 p.m. Coffee Break
- 3:05 p.m. "Current Trends in Weight Training"
Mike Kittleson, Weight Training Coach, University of Michigan, Ann Arbor
- 3:45 p.m. "The Recognition and Diagnosis of Knee Joint Difficulties"
Joseph Godfrey, MD, Buffalo, NY
- 4:25 p.m. Summary and Closing Comments
Doctor Guise

REGISTRATION FORM

Please return to: MSMS Sports Medicine Conference
PO Box 950, East Lansing, MI 48823 Phone: 517/337-1351

Name _____

Address _____

City _____ State _____ Zip _____

Check one: (Registration fee includes lunch)

- ☐ Physician (\$20) ☐ Trainer (\$15) ☐ Coach (\$15) ☐ Other (\$15)

Please make checks payable to Michigan State Medical Society

A UNIFORM PROCEDURE CODING SYSTEM long sought by MSMS for insurance claim forms is being prepared for use by federal programs. The procedure coding system is based on the AMA's CPT-4 and a uniform claim form developed by the AMA, the Health Insurance Assn. of America and the Blue Cross and Blue Shield Associations. The CPT-4 would be modified and made suitable for all care settings and is expected to be ready for testing in 1981. Blue Cross Blue Shield of Michigan is preparing to use the nationwide uniform procedure coding system in its regular business, as well as the federal programs it administers, with basically the same timetable for introduction. BCBSM also has plans to implement the new uniform diagnostic code, HICD-9CM, at the same time it begins to use the uniform procedure coding system. MSMS expects to work with the Michigan Hospital Association and medical records personnel to ease these changes.

MSMS House of Delegates to meet April 25-27 in Southfield

The MSMS House of Delegates Annual Meeting April 25-27 at the Michigan Inn, Southfield, is fast approaching. The deadline for resolutions for the House's consideration was March 25, and the deadline for delegates to make room reservations is April 10. The housing forms were mailed recently to each delegate and alternate and are to go directly to the hotel.

New bill would bring MEs relief

A new work classification in the medical examiner system called "medical examiner investigator" would be established under Substitute House Bill 5401, reported to the full House by the Public Health Committee. The bill answers problems of certain counties who have no physicians for routine medical examiner investigations. The medical examiner investigator may be appointed by the county medical examiner "to assist the examiner in carrying out the duties required by this act. The examiner shall determine the qualifications of the investigator, taking into consideration the person's education, training, or experience, and shall be solely responsible for determining the duties assigned." The bill requires that all medical examiners and deputy examiners be licensed physicians.

MSMS co-sponsors oral cancer symposium

MSMS is co-sponsoring an all-day Category I Oral Cancer Symposium April 9 at Adrian's Ramona Terrace, in Comstock Park, near Grand Rapids. Co-sponsors are the Michigan Dental Association, West Michigan District Dental Society and the American Cancer Society, Michigan Division. Physicians attending the program will earn five Category I credits. Please contact June Asselin, education coordinator, Michigan Dental Association, 230 N. Washington, Lansing, 48933.

Michigan State Medical Society
120 West Saginaw Street
East Lansing, Michigan 48823

MICHIGAN MEDICINE

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Editor: Judith Marr

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MICHIGAN MEDICINE

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Vol. 79, No. 10

April 14, 1980

APR 30 1980

Breaking News for Michigan Doctors

MEDIGRAM

1980 Continuing Medical Education Records 1980

In this issue . . .

This Medigram contains the 1980 physicians' folder for recording and documenting continuing medical education activities. The folder also provides basic information about CME rules and regulations in Michigan, through a question and answer format on the first page. Please remove this folder and retain for your office use.

This Medigram also includes a report by MSMS headquarters on key medical legislation. Prepared by the MSMS Department of Government Relations, the report lists approximately 25 health care bills, their status in the law-making process and MSMS positions. Be sure to bring yourself up to date with this important communication.

CAPSULES

MSMS AUXILIARY MEMBERS from around the state will gather at Kellogg Center, East Lansing, on April 21 for the auxiliary's annual Legislative Day. Auxiliaries will explore medical legislative issues and MSMS positions. Speakers will include Wayne Bradley, director, AMA Division of National Legislation; State Sen. Edward Pierce, MD; MSMS President Ernest P. Griffin, Jr., MD, and Bruce W. Ambrose, manager, MSMS Department of Government Relations. Auxiliary members will have luncheon with their legislators.

Detroit, Flint-area plans pass SHCC bed reduction comm.

Plans for reducing numbers of hospital beds in southeast Michigan and Genesee-Lapeer-Shiawassee counties were okayed April 8 by the Bed Reduction Committee of the Statewide Health Coordinating Council. The SHCC committee continued to carry out its responsibilities despite recent action by the Joint Committee on Administrative Rules which March 25 disapproved the state's criteria for bed reduction plans. The Joint Committee's action followed the MSMS Council's call for a moratorium on bed reduction activity, objections of hospitals and other Michigan physician groups.

The SHCC committee attached some conditions to its approval of the Detroit-area bed reduction plans. One condition is that the Comprehensive Health Planning Council of Southeast Michigan not engage in implementing the plan for 90 days to permit a special joint legislative committee to examine the plan and the process used to develop it. Other conditions require that the plan be revised in the next annual revision to provide greater specificity in describing hospital bed reductions, and to increase the bed reduction target to at least the state-mandated number of 2,483 beds.

The GLS bed reduction plan also was passed by the committee with the condition that the plan provide greater specificity in the next annual revision. The Southeast Michigan and Genesee-Lapeer-Shiawassee bed reduction plans are the last of the six plans required in Michigan to be received by the SHCC. The other four plans have been approved by the SHCC. The Detroit-area plan includes concessions previously won to exempt five hospitals serving primarily black, inner-city residents, and Martin Place Hospital, which obtained a court injunction withdrawing it from bed reduction activity.

MSMS forms CME policy group

A new MSMS committee is forming to study the broad issues confronting medical education and to serve as a coordinating body for MSMS continuing medical education activities. Asked to serve on the committee are Carl F. Hammerstrom, MD, chairman, MSMS Committee on CME Programming; Samuel J. McMahon, MD, chairman, MSMS Annual Scientific Meeting Task Force; Richard W. Pomeroy, MD, chairman, MSMS Committee on CME Accreditation; E. James Potchen, MD, member, AMA Council on Medical Education. Charles C. Vincent, MD, associate dean for student affairs, Wayne State University School of Medicine, will chair the new committee.

CAPSULES/continued

CHANGE IN PLANS...James D. Fryfogle, MD, Detroit, will appear on the April 21 "Focus" interview program of Detroit radio station WJR, rather than the April 3 date announced earlier. Doctor Fryfogle, speaker of the MSMS House of Delegates and chairman, Seven-County Physicians Health Planning Advisory Council, will discuss southeast Michigan hospital bed reduction plans with "Focus" host J. P. McCarthy. The program airs at 12:15 p.m.

RULES AND REGULATIONS regarding treatment, control, and reporting of venereal diseases are the subjects of public hearings scheduled in April by the Michigan Department of Public Health. Interested physicians may obtain copies of the rules and regs by contacting the Venereal Disease Division, MDPH, 3500 N. Logan, Box 30035, Lansing, 48909. The hearings are scheduled April 14 in Lansing; April 21 in Grayling; April 22 in Marquette; April 24 in Grand Rapids, and April 28 in Detroit.

MONTHLY GROUP RATES increase just 2.5 percent in 1980 for the medical assistants covered under the MSMS group insurance program. The MSMS group policy 94001 with Blue Cross Blue Shield of Michigan covers medical assistants working in physicians' offices. "Considering the overall increase in costs, we think this is a remarkably small raise," says Wayne Burmeister, manager of the MSMS Department of Operations and Member Services. For further information, please contact Mr. Burmeister at MSMS headquarters, 517/337-1351.

MSMS learns of problems in Medicaid second opinion program

The Michigan Medicaid system's required second surgical opinion program went into effect earlier this year, and MSMS has reports of a number of problems. They include low reimbursements for consultations, lack of physician participation, no-shows for the consultations on the part of Medicaid patients, complexities of giving second opinions, unequal treatment for rural, less accessible segments of the population and general physician resistance to another governmental regulation on the practice of medicine.

The MSMS Medicaid Liaison Committee now reports neither the legislature nor administrative branches of government have lived up to their commitments to update Medicaid physician screens, which the Department of Social Services promised when the plan was instituted.

Economy detrimental to Medicaid

A series of current economic trends will have a detrimental effect on the Medicaid program not only for the remainder of this fiscal year, but for the fiscal year 1980-81 as well. The current state recession is projected to raise the unemployment rate to about 10.5 percent and has already had the effect of creating an explosion in social welfare payments which threaten to cost \$140 million more than had been expected this year. A supplemental appropriation will have to be enacted by the Michigan Legislature to cover the shortfall. Although the supplemental legislative proposal has yet to be transmitted from the executive branch to the legislature, it is anticipated to contain the increase in physician screens promised last October, last December and again this March. As bleak as the fiscal picture is for the remainder of this year, it is even worse for fiscal year 1980-81 which begins Oct. 1. President Carter has proposed the elimination of approximately \$100 million in federal revenue sharing for Michigan. There is also a possibility of a severe reduction in categorical program assistance. These actions, coupled with the increase in the Medicaid caseload and a decrease in real personal income, mean drastic cuts in the total state budget including previously untouched areas such as school aid, higher education and Medicaid benefits. Of concern to the Medicaid Liaison Committee is the possibility of cuts in provider reimbursements reminiscent of the crisis situation in 1975 when physician fees were cut 11 percent.

MICHIGAN STATE MEDICAL SOCIETY

120 WEST SAGINAW STREET,
EAST LANSING, MICHIGAN 48823

Detach and Retain as a File Folder

MSMS, in cooperation with the Michigan Board of Medicine, developed this Medigram section to help physicians to understand the new CME rules and to keep their records of attendance.

Has the reporting of CME rules compliance changed?	Yes. You still certify compliance by signing the CME part of your re-registration card, but, like registration, the certification frequency is changing to a three-year cycle.
Must I re-register for 1981?	Yes, IF you got a one-year registration (green-banded card, \$25.00 fee) for 1980. About Nov. 1 the Board of Medicine will send you an application for a three-year renewal.
If I don't get an application?	Check your records--did you register and pay for two or three years (\$50.00 or \$75.00, respectively) last December?
What does compliance require beyond earning CME hours?	Keeping evidence of compliance for four years and being ready for a board audit. (see copy of statement below)
What kind of evidence will be sufficient for the auditors?	Certificates of completion, receipts, cancelled checks--the same type of proofs asked by the Internal Revenue Service.
How important is the evidence?	Failure to provide it shall be deemed to establish a rebuttal presumption that the licensee made a false or fraudulent statement in applying for a license.
But don't the sponsors keep records of their CME activities?	Yes, but only to substantiate your claims of participation. As with IRS data, it's your responsibility to keep records.
How should I keep the evidence?	Carefully organized year by year in a folder like this.
What is the CME year?	January 2-December 31.
Does service on a peer review committee count as CME?	Yes, hour for hour credit in Category 5 up to 18 hours in three years.
Do CME requirements include medical ethics studies?	Yes, your three-year record must include Category 1 courses upgrading your skills dealing with issues of life and death.
Who can help me with questions about my CME compliance?	Contact the Michigan Board of Medicine, 905 Southland, P.O. Box 30018, Lansing, MI 48909; telephone 517/373-0680.

CERTIFICATION OF COMPLIANCE

I hereby certify that I have earned 150 hours of Continuing Medical Education in the preceding 3 years (1978-79-80), including a minimum of 75 hours in Category 1; or 100 hours of Continuing Medical Education in the preceding 2 years if originally licensed in Michigan in 1979, or 50 hours of Continuing Medical Education in the past year if originally licensed in Michigan in 1980. I understand that it is my responsibility to maintain evidence of my compliance with the CME requirements, that this evidence must be kept for a period of 4 years and that I am subject to an audit of all such evidence. I acknowledge that the Michigan Board of Medicine considers this a part of my application for renewal of medical licensure.

(signature)

(date)

Retain this folder to record activities and to hold CME programs, notes, receipts

Category 1

Activities with accredited sponsorship;
tutorial experience; medical ethics;
specialty board certification/recertification

1978 cr.hrs. _____

1979 cr.hrs. _____

Minimum credit hours (clock hours) in three years: 75; maximum, 150.

ACTIVITY _____ Date _____ cr.hrs. ____/____

Sponsor or tutor _____ Location _____

ACTIVITY _____ Date _____ cr.hrs. ____/____

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Sponsor or tutor _____ Location _____

MICHIGAN STATE MEDICAL SOCIETY

Division of Government Relations
Status Report
of
Proposed Legislation, 1980

House of Representatives

HB 4259 OFFICE OF INSPECTOR GENERAL - MEDICAID FRAUD

Sponsor: T. Stopczynski, S. Stopczynski, Hadden, et al.

This bill would establish the Office of Inspector General within the Department of Social Services to investigate alleged social services fraud by applicants, recipients, and employees of service providers.

Status: Third reading with substitute on House Floor.

HB 4349 CPR REQUIRED IN HIGH SCHOOL PHYSICAL EDUCATION

Sponsor: Bullard, M. Brown, J. Young, et al.

This bill would require cardiac pulmonary resuscitation as mandatory curricula of high school physical education courses.

Status: House Floor

HB 4555 BLUE CROSS BLUE SHIELD OF MICHIGAN RESTRUCTURING

Sponsor: Hollister and Ryan

This bill is the culmination of months of compromise and controversy in reorganizing BC/BSM. The bill addresses three major areas of concern: Board reorganization, regulation, cost containment and internal operations. The size of the Board is reduced from 47 to 33 members with providers having approximately 25% representation. This piece of legislation is specific in regulation and guidelines for cost containment. The bill allows Blue Cross/Blue Shield and each provider group to develop a provider plan. The provider plan must establish quantifiable and achievable goals. After two years, the Insurance Commissioner will review the plan. If the goals are met, the state will play no role and there will be no regulation of BC/BSM. The plan remains unchanged for two additional years. If the Insurance Commissioner decides the goals have not been met - without good cause - the corporation may draft a new plan or resubmit the old plan; the Insurance Commissioner also develops a plan. A three member Appeal Board (one appointed by the State-wide Health Coordinating Council, one appointed by the SHAC and one appointed by the Commissioner also develops a plan, and determines which plan will prevail or the Appeal Board may combine portions of the plans with the consent of the parties. The plans may be appealed to the Appellate Court.

Status: This is the content of bill as it passed the House. It has been referred to the Senate Commerce Committee which has made some changes. At this time it appears the bill will end up in a Conference Committee to settle the differences between the House and Senate versions.

MSMS Position: Support

HB 4580 IMMUNITY FOR RENDERING CPR

Sponsor: Barcia, Gnodtke, Dutko, et al.

This bill would provide immunity for persons rendering cardio-pulmonary resuscitation.

Status: Passed House-Senate Judiciary

- HB 4648 DETERMINATION OF DEATH ACT
Sponsor: Symons and R. Hood
This bill defines that a person is considered dead, if in the opinion of the attending physician, there is irreversible cessation of spontaneous respiratory and circulatory functions. It further requires that a person must be declared dead before artificial life support functions are terminated.
Status: Signed by the Governor, PA 124 of 1979
- HB 4665 HOSPITAL REPORTING ON CASES OF CHILD ABUSE
Sponsor: Clodfelter, Burkhalter, Spaniola, et al.
This bill would require hospitals to examine suspected cases of child abuse and file a report of their findings. The bill outlines penalties for failing to file reports.
Status: Passed House - Referred to Senate Judiciary
- HB 4909 DEFINES HOSPICE PROGRAM
Sponsor: Hollister
This piece of legislation defines a hospice program as designed to meet the physical, psychological, social, and spiritual needs of a person and his family during the final stages of a terminal illness.
Status: Passed House, Referred to Senate Health and Social Services Committee.
- HB 4913 PROVIDE FOR RELEASE OF INFORMATION RELATING TO ETHICS AND STANDARDS OF HEALTH CARE PROFESSIONS
Sponsor: R. Hood
This bill would provide for the release of information for medical research and medical education purposes, it would limit liability with respect to the release of this information and would safeguard the confidentiality of the information contained.
Status: Signed by the Governor PA 3 of 1980
- HB 5237 DEPARTMENT OF SOCIAL SERVICES APPROVAL ON HOSPITAL EXPENSES AND FEE SCHEDULES
Sponsor: Owen, Bryant, and Ryan
This act requires the Department of Social Services to enter into agreement with each hospital operated by a non-profit corporation to provide for the Department of Social Services to approve expenses and fee schedules to be received by the hospital for the hospitalization of persons eligible under this act.
Status: PA 216, October 1, 1980
- HB 5376 AUTOPSY FOR CASES OF SUDDEN INFANT DEATH
Sponsor: R. Hood and Collins
This bill would require an autopsy when sudden infant death results from unknown causes.
Status: House Public Health with substitute
- HB 5398 IDENTIFY PRIORITY CHRONIC DISEASE PROBLEMS
Sponsor: R. Hood
The purpose of this bill is to establish a methodology for determining priorities in chronic diseases and for providing public input into the process of determining which services will be offered and how much money will be spent for those services. The bill is intended to open the process to

legislators and the public as well.

Status: House Public Health Committee

HB 5401 CREATES MEDICAL EXAMINER INVESTIGATORS

Sponsor: VanSingen

This bill would allow county medical examiners to appoint a "medical examiner investigator" to assist the county medical examiner in carrying out the duties required. The county medical examiner shall determine the qualifications of the "investigators", taking into consideration the person's education, training or experience, and shall be solely responsible for determining the duties assigned to the investigator.

Status: House Public Health

MSMS Position: Support as amended by MSMS

HJR T REQUIREMENTS FOR EXAMINING OR LICENSING BOARD MEMBERSHIP

Sponsor: Jondahl, Padden, Evans, et al.

This joint resolution would call for an amendment to Section 5 of the Constitution to strike the requirement that a majority of members of an appointed examining or licensing Board of a profession be members of that profession. This question would be subject to vote of the people.

Status: Committee on Constitutional Revision and Women's Rights

MSMS Position: Oppose

HCR 578 DEBEDDING OVERSIGHT COMMITTEE

Sponsor: Brotherton

This House Concurrent Resolution creates the legislative oversight committee for the bed reduction process in southeast Michigan. It also calls for a 3 month moratorium on the implementation of the bed reduction program.

Status: Concurred in by both chambers of the legislature

MSMS Position: Support

Senate

SB 185 CONTROLLED SUBSTANCES THERAPEUTIC RESEARCH PROGRAM

Sponsor: Monsma, et al.

This legislation would establish a Controlled Substance Therapeutic Research Program. This program would conduct research using marijuana to treat patients suffering with a life or sense threatening situation due to glaucoma or cancer chemotherapy treatments. Patients would have to be physician certified and then approved by a three-member patient qualification review board. Twenty statewide pharmacists will be designed for distribution to patients in the program.

Status: Signed by the Governor, PA 125 of 1979

SB 374 REPEAL OF DRUG CONTROL LICENSE

Sponsor: DeGrow, Geake, VanderLaan, et al.

This legislation would repeal section 17745 of the Public Health Code which requires physicians who routinely dispense drugs from their offices to obtain a Drug Control License. A substitute has been offered which calls for physicians to obtain the license on a one time permanent basis. It also deletes the requirement for the price chart.

Status: Senate Health and Social Services Committee

MSMS Position: Support

- SB 457 EXTEND BROWN-McNEELY FUND
Sponsor: Hertel, Faust, DeMaso, et al.
This bill would extend the Brown-McNeely Fund until December 31, 1981.
Status: Senate Floor
- SB 778 BLUE CROSS BLUE SHIELD OF MICHIGAN PARTICIPANTS
Sponsor: Ross, Corbin, Geake, et al.
This bill would provide that a medical care corporation may add licensed psychologists to become participating service providers.
Status: Passed Senate referred to House Insurance Committee
MSMS Position: Oppose
- SB 842 EXEMPTS COLLEGE PHARMACIES FROM OWNERSHIP REQUIREMENTS
Sponsor: Engler, Allen, Huffman, et al.
This bill would exempt college and university pharmacies from certain ownership requirements, as outlined in the Public Health Code.
Status: Passed House and Senate - waiting for Governor's signature.
- SB 862 DEPARTMENT OF SOCIAL SERVICES APPROVAL ON HOSPITAL EXPENSES AND FEE SCHEDULES
Sponsor: Huffman
Same as HB 5237
Status: Senate Appropriations
- SB 866 CREATES DESIGNATED MENTAL HEALTH PROFESSIONS
Sponsor: Pierce
This bill provides that county mental health directors may designate psychologists, registered nurses with an MA in psychiatric nursing and social workers as "designated mental health professionals". These designated mental health professionals may execute required certificates for hospitalization of patients in need of psychiatric care.
Status: Senate Floor with substitute
- SB 886 PHYSICIAN ASSISTANT MUST INFORM PATIENTS
Sponsor: G. Hart, Pierce, Kelly, et al.
This bill would require a physician assistant to inform a patient of his status prior to rendering care.
Status: Senate Health and Social Service Committee

Appropriations for Fiscal Year 1980-81

Executive budget recommendations for the major departments, including social services, public health, and mental health were transmitted to the Legislature early in the year. However, in the time that has elapsed the state's economic situation and anticipated actions at the federal level indicate a short-fall of at least \$200 million. President Carter has proposed elimination of approximately \$100 million in federal revenue sharing for Michigan and there is a possibility of a severe reduction in categorical program assistance. These actions, coupled with the increase in Medicaid caseload and a decrease in real personal income, mean drastic cuts in the total state budget including previously untouched areas such as school aid, higher education and Medicaid. Of concern to MSMS is the possibility of cuts in provider reimbursements reminiscent of the crisis situation in 1975 when physician fees were cut 10 percent.

Category 2

Activities with nonaccredited sponsorship

1978 cr.hrs. _____

Maximum credit hours (clock hours) in three years: 36.

1979 cr.hrs. _____

ACTIVITY _____ Date _____ cr.hrs. ____/____

Sponsor _____ Location _____

ACTIVITY _____ Date _____ cr.hrs. ____/____

Sponsor _____ Location _____

ACTIVITY _____ Date _____ cr.hrs. ____/____

Sponsor _____ Location _____

Category 3

Teaching physicians or allied health services

1978 cr.hrs. _____

Maximum credit hours (two per clock hour)
in three years: 48.

1979 cr.hrs. _____

ACTIVITY _____ Audience _____ cr.hrs. ____/____

Sponsor _____ Location _____ Date _____

ACTIVITY _____ Audience _____ cr.hrs. ____/____

Sponsor _____ Location _____ Date _____

ACTIVITY _____ Audience _____ cr.hrs. ____/____

Sponsor _____ Location _____ Date _____

Category 4

Books, papers, publications, and exhibits

1978 cr.hrs. _____

Maximum credit hours (clock hours) in three years: 48.

1979 cr.hrs. _____

ACTIVITY _____ Date _____ cr.hrs. ____/____

Event and place
Publication or publisher _____

ACTIVITY _____ Date _____ cr.hrs. ____/____

Event and place
Publication or publisher _____

ACTIVITY _____ Date _____ cr.hrs. ____/____

Event and place
Publication or publisher _____

Category 5

Nonsupervised education

1978 cr.hrs. _____

Maximum credit hours (clock hours) in three years: 36.

1979 cr.hrs. _____

Self-assessment (Maximum credit hours: 18)

Self-instruction (Maximum credit hours: 18)

Quality care or utilization review (Maximum credit hours: 18)

ACTIVITY _____ cr.hrs. ____/____

ACTIVITY _____ cr.hrs. ____/____

ACTIVITY _____ cr.hrs. ____/____

Category 6

Full-time participation in graduate training program
of at least five full months

1978 cr.hrs. _____

1979 cr.hrs. _____

Maximum credit hours: 50 per year.

PROGRAM SITE _____

Program dates _____

CONTINUING MEDICAL EDUCATION RULES INFORMATION

The Michigan Board of Medicine will mail complete copies of the revised CME rules to all Michigan licensees. All requests for additional information should be sent to:

Michigan Board of Medicine
905 Southland
P.O. Box 30018
Lansing, Michigan 48909
Telephone 517/373-0680

The board may deny a request for approval of activities for CME credit whenever it appears that the request fails to demonstrate compliance with the legislative intent to further educate licensees on subject related to the practice of medicine.

SUMMARY OF CME CREDIT

	1978	1979	1980
Category 1	_____	_____	_____
Category 2	_____	_____	_____
Category 3	_____	_____	_____
Category 4	_____	_____	_____
Category 5	_____	_____	_____
Category 6	_____	_____	_____
TOTALS	_____	_____	_____

MSMS committee discusses MD office accessibility checklist

Intense discussion centered on Section 504 of the Rehabilitation Act at the last meeting of the MSMS Medicaid Liaison Committee. Representatives of the Michigan Department of Social Services agreed that the act's detailed checklist of physical accessibility requirements for physicians' offices is excessive, but said non-compliance would jeopardize federal funds to the state. Physicians are reminded the checklist is a self-evaluation to be retained in the office files and need not be returned to MDSS.

Ronald Eggleston, MDSS coordinator for Section 504, will assist physicians with the self-evaluation and can be contacted at (517) 373-7720.

Wayne State beginning search for new med school dean

A search and selection committee is at work to find a successor to retiring Wayne State University School of Medicine Dean Robert D. Coye, MD. Dean Coye will remain at his post until September, when he plans a year's sabbatical before taking up teaching duties in the WSU medical school. Chairman of the search and selection committee is Martin Barr, PhD, WSU vice provost for academic administration and health affairs. MSMS members on the 12-person committee are Darwin Belden, MD, associate professor of family medicine; Ralph Cushing, MD, associate professor of internal medicine; Larry Fleischmann, MD, associate professor of pediatrics; A. Martin Lerner, MD, professor of internal medicine; Franklin McDonald, MD, professor of internal medicine; Gino Saliccioli, MD, associate professor of orthopedic surgery; and Alexander Walt, MD, professor and chairman of surgery.

19 MSMS members better negotiators

Nineteen MSMS members attended a recent seminar tailored to enhance leadership ability by developing improved negotiation skills. MSMS and AMA presented the leadership seminar in Lansing on Feb. 16-17. MSMS members who attended were: David H. Barker, MD, Grosse Pointe Farms; Ernest M. Berkas, MD, Dearborn; Donald C. Camp, MD, Niles; Stuart L. Cohn, MD, Alpena; John W. Coles, MD, Mt. Pleasant; George R. Gerber, MD, Rochester; John W. Hayden, MD, Wayland; Louis E. Heideman, MD, Birmingham; Hugo R. Saenz, MD, Lansing; Joseph L. Schirle, Jr., MD, Pontiac; Francis P. Shea, MD, Grosse Pointe; Marguerite R. Shearer, MD, Dexter; Marshall L. Shearer, MD, Dexter; Timothy M. Talbott, MD, Grand Rapids; Allen F. Turcke, MD, Flint; Theodore S. Vanderveen, MD, Grand Rapids; Charles Whitten, MD, Detroit; Louis R. Zako, MD, Dearborn Heights and Michael Zele-nock, MD, Southgate.

CAPSULES/continued

WOTV-CHANNEL 8, Grand Rapids has a new live medical interview series in cooperation with the Kent County Medical Society. Four minute physician interviews air during the noon news segment one day every other week. Generally, the segment repeats as part of the regular 6 p.m. news. James Muldoon, MD, Grand Rapids, is local coordinator and assists Curt Fonger, WOTV news director and noon anchorman, in arranging local physicians' talks on a wide range of medical topics. MSMS staff helped arrange the new venture as part of the overall MSMS effort to get medicine before the public in a positive manner.

BERT BRENNAN, BOARD OF MEDICINE executive director, reminds physicians to contact the board within 30 days if their address changes. The Public Health Code requires physicians to notify the board in 30 days, to ensure that physicians receive all necessary communications.

PEDIATRIC HYPERTENSION and screening for cardiac diseases in the young are the topics of two desk reference cards published in the March issue of Michigan Medicine. The desk reference cards, printed on heavy green stock, are designed to be removed from the magazine and filed for handy reference. The cards were prepared by the Michigan Heart Association. Interested physicians are encouraged to keep and use the folders.

THE MSMS DEPARTMENT OF GOVERNMENT RELATIONS has been revamped to recognize two major areas of concern. Two MSMS staff members will work closely with Department Manager Bruce W. Ambrose, to carry out those responsibilities. They are Sherry N. Wellman, whose title now is coordinator for public policy and political affairs, and Dennis M. Paradis, whose new title is coordinator for health planning and special government projects.

CAPSULES/continued

MSMS LEGAL COUNSEL is expecting word momentarily on its motion asking for fuller and more complete answers to interrogatories (written questions) requiring factual details supporting the Federal Trade Commission's allegations against MSMS. Legal counsel also has asked for an adjournment of the June 2 trial to a later date, for more time in preparing the MSMS case.

MSMS MEMBERS ARE INVITED to an open meeting from 3 to 5 p.m. April 17 at MSMS headquarters of an ad hoc task force reviewing MSMS Department of Government Relations operations. The task force of the MSMS Committee on State Legislation and Regulations is making a constructive effort to meet the rapid changes of government. Task force chairman is Thomas R. Stone, MD, Muskegon.

THE LEGISLATURE RECESSED for Easter with the Blue Cross Blue Shield of Michigan reform bill (HB 4555) still before the Senate Commerce Committee, chaired by Arthur J. Miller, Jr., (D-Warren). Hearings on the bill are proceeding. Should a version of the bill pass the senate soon, it now appears conference committee action between the House and Senate versions of the bill is likely.

MSMS House to consider 55 resolutions

The MSMS House of Delegates will consider 55 resolutions submitted by component societies when it convenes April 25-27 in annual session at the Michigan Inn, Southfield. The resolutions are being processed at MSMS headquarters now and will be included in the delegates' handbook to be mailed just prior to the meeting.

A highlight of the three-day annual meeting will be the installation of John R. Ylvisaker, MD, Pontiac as MSMS president. His successor will be chosen in annual elections scheduled during the House of Delegates sessions.

In other special events, former AMA President Edward R. Annis, MD, of Miami, Fla., will address an open forum on "Medical Costs, Government and Common Sense," at 3 p.m., Saturday, April 26. The annual Michigan Doctors Political Action Committee luncheon at noon Sat., April 26, will feature Lt. Gov. James Brickley and St. Sen. Douglas Ross (D-Oak Park).

Clinical investigators sought for marijuana research

The Michigan Department of Public Health is planning to enroll clinical investigators in a research project to study the efficacy of marijuana in controlling nausea and vomiting associated with intensive cancer chemotherapy. Qualified, interested physicians should first write: John L. Isbister, MD, Disease Control Officer, Michigan Department of Public Health, P.O. Box 30035, Lansing, 48909. The following are the criteria for participation as a clinical investigator:

1. License to practice medicine or osteopathy in Michigan and currently practicing in this state.
2. Drug Enforcement Administration registration for Schedule I research under the Michigan protocol.
3. Board of Pharmacy registration with Schedule I research designation.
4. Engaged in the intensive chemotherapy of cancer.
5. Knowledgeable about the side effects of marijuana.
6. Agree to follow study protocols, as directed by the principal investigator.

Michigan State Medical Society
120 West Saginaw Street
East Lansing, Michigan 48823

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Editor: Judith Marr

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MICHIGAN MEDICINE

April 1980

JOURNAL OF THE MICHIGAN STATE MEDICAL SOCIETY

Vol. 79, No. 11



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Who to call at MSMS headquarters

Advertising (in <i>Michigan Medicine</i>)	Bonnie Groff
AMA Delegation	Bruce Ambrose, Wayne Burmeister
Annual Scientific Meeting	
Program	Sherry Fent
Meeting Arrangements	Marce Ireland
Arbitration	Bill Madigan
Auto Lease Plan	Wayne Burmeister
Blue Cross Blue Shield	John Richards
Board of Medicine	Gary Anderson
Continuing Medical Education	
Accreditation	Marce Ireland
Category I Calendar (for <i>Michigan Medicine</i>)	Bonnie Groff
MSMS-Sponsored Conferences	Sherry Fent
Financial Operations	Dick Campau
Foreign Medical Graduates	Mert Scholten
Governmental Agencies Liaison	Sherry Wellman
Health Career Information	Mert Scholten
HMOs (Health Maintenance Organizations)	Dick Campau
HSA Support Center	Dennis Paradis
Impaired Physicians	Mert Scholten
Jail Health Project	David Schut
Judicial Commission	Vada Davis
Legislation	Bruce Ambrose
Maternal Health Committee and Conference	Katie Brewbaker
Medicaid	Sherry Wellman
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Medical Auxiliary	Caroline Rich
Medical Care Costs	Dick Campau
Medical Ethics	Vada Davis
Medigram	Judy Marr
Meeting Information (National, State)	Bonnie Groff
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Membership Records	Peg Berry
Michigan Association for Medical Education	Tanya Miller
Michigan Doctors Political Action Committee	Gary Anderson
<i>Michigan Medicine</i> (MSMS Journal)	Judy Marr
Michigan Ophthalmological Society	Tanya Miller
Michigan Physicians Mutual Liability Company	Bill Cheeseman
Michigan Psychiatric Society	Helen Schulte
Michigan Society of Anesthesiologists	Tanya Miller
Michigan Society of General Surgeons	Caroline Rich
Michigan Society of Respiratory Therapists	Caroline Rich
MSMS Committee Meeting Schedule	Katie Brewbaker
MSMS House of Delegates	
Agenda and Schedule	Dick Campau
Meeting Arrangements	Marce Ireland
MSMS-Sponsored Insurance Programs (Life, Health, etc.)	Wayne Burmeister
MSMS Travel Programs	Marce Ireland
MSMS News Relations	Mert Scholten
Physicians' Assistants	Gary Anderson
Physician Hospital Relations	Dick Campau
Physician Legislative Network	Gary Anderson
Physician Service Group	John Anthony
Practice Management Seminars	John Anthony
Professional Liability Insurance	Bill Madigan
PSRO	Sherry Wellman
Socio-Economic Surveys	John Richards
Specialty Societies	
Information	Katie Brewbaker
Council of Specialty Societies	Bill Madigan
Third Party Payors	John Richards

MSMS ADDRESS: Michigan State Medical Society MSMS PHONE: 517/337-1351
120 West Saginaw (Box 950)
East Lansing, MI 48823



Pediatricians, obstetricians, gynecologists, family physicians, nurses, medical and nursing students crowd the annual MSMS-sponsored Michigan Conference on Maternal and Perinatal Health. MSMS continuing medical education efforts are spotlighted in this month's special report. (Photo by Mert Scholten, MSMS staff.)

MICHIGAN MEDICINE

April 1980, Volume 79, Number 11

Special report

- 80** Physicians' changing needs have made big changes in MSMS continuing medical education programs. The MSMS CME Programming Committee works to insure the MSMS Annual Scientific Meeting, Maternal Health Conference, Sports Medicine Conference and other CME offerings meet state requirements and members' needs; Carl F. Hammerstrom, MD; Herbert A. Auer; Sherry L. Fent

Features

- 188** Physicians watch Medicaid payments to their colleagues in the state's excellent Professional/Technical Peer Review Group; Giovannino A. Perri, MD
- 195** The Michigan Department of Licensing and Regulation; Gary Anderson
- 198** Michigan's new Public Health Code requires more immunizations; William F. Simonsen, SrPHA
- 202** Board of Medicine's Doctor Kuiper chafes under Public Health Code restrictions; Charles R. Downs
- 203** Meet the physician members of the Michigan Board of Medicine
- 206** Legislative profile: Sen. Gary Corbin
- 210** Michigan's Doctor Ochberg advising in Iranian hostage situation; Willah Weddon
- 215** Doctor Stack leaving public life for new mental health practice; Martha Smith
- 218** Meet the staff members of the MSMS Office of the Director

Departments

- 176** In my opinion; Harvey M. Andre, MD
- 177** Letters
- 208** Health Planning Update
- 219** Ad Index
- 220** News
- 222** Meetings
- 224** Category I courses
- 228** MSMS/A
- 228** Classified ads
- 230** MSMS Q/A

Medical profession burdened by restrictions

By Harvey M. Andre, MD, Grand Rapids



We are now in the fifth year of continuing medical education requirements for the license to practice medicine in the state of Michigan.

I believe that most of the practicing physicians in this state in the years prior to this legal requirement attended enough meetings, seminars and university conducted courses to average approximately 50 hours of learning experience per year in keeping abreast of advances in their fields. This was done not only for self-confidence and personal satisfaction, but to provide the best care possible for their patients.

I am sure there are no other professional fields where the practitioners as a whole sought to keep their skills as sharp as those in the practice of medicine.

Now, however, we must be able to prove we have been diligent in upgrading our practice. No other profession is required by law to prove they are continuing their education every year!

But even this is not enough!

We now are facing the prospect of having second opinions recorded on particular forms to demonstrate that we are delivering the proper standards of care. The Blues have put this in effect on certain procedures for Medicaid patients. It is but a short step to require this on all procedures for all Blue Shield subscribers.

Similar restrictions have not been placed on other professions. Consider the architects who designed a college building for the state in western Michigan. The poorly-designed dome roof gave problems from the beginning and now is declared unsafe. The same firm again has been employed by the state to design another building in the eastern part of the state. No second opinion was needed to check their plans.

Or consider the engineers who designed the US 131 freeway through Grand Rapids. The S curves have been a problem from the opening of the freeway and, in fact, the grade levels had to be redone a couple years ago. Are these same engineers being required to have a second opinion on their future drawings?

We all know of reports of accounting errors, when suddenly a city finds several millions of dollars on hand, when its citizens were told a deficit threatened. Are these accountants required to have a second opinion?

It is high time we in the medical profession educate the public that our profession as a whole is providing quality care at a reasonable cost, and that we are being burdened with restrictions imposed by the government and the insurance industry which will only increase costs! No other profession is so hampered. "Equality and justice for all" is a mockery.

Michigan Medicine welcomes replies and responses to the monthly "In my opinion" column.

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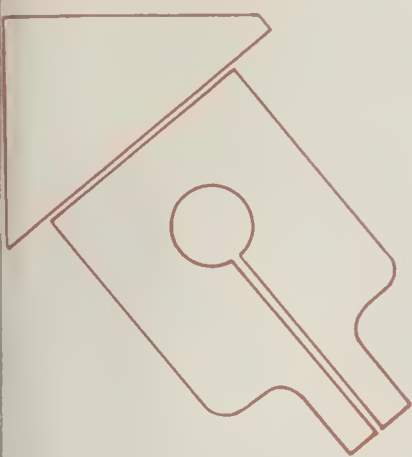
Michigan Medicine, the official journal of the Michigan State Society, is dedicated to provide useful information for Michigan physicians about actions of the Michigan State Medical Society and contemporary issues, with special emphasis on socio-economics, legislation and news about medicine in Michigan. Major medical developments will be reported and interpreted as has been the custom.

The Michigan State Medical Society Committee on Publications is the editorial board of *Michigan Medicine* and advises the editors in the conduct and policy of the magazine, subject to the policies of the MSMS Council.

Neither the editors nor the state medical society will accept responsibility for statements made or opinions expressed by any contributor in any article or feature published in the pages of the journal. The views expressed are those of the writer and not necessarily official positions of the society. Products and services advertised in *Michigan Medicine* are neither endorsed nor warranted by MSMS.

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Care of the dying course presented by Cottage Hospital

"The Caring Person," a continuing series of monthly programs and information sessions for those who must care for the dying, particularly cancer patients, is underway Monday evenings at Cottage Hospital, Grosse Pointe Farms.

Health care professionals from a variety of specialties including nursing, physical therapy, dietary, pharmacy, occupational therapy and social work speak about the application of their techniques and skills to the needs of the patient cared for at home.

The program was developed by the Cottage Hospital Nursing department. Mrs. Sondra Seeley, RN, head nurse, is the originator and coordinator.

We invite all who are interested to attend.

Madge B. Lawson
Public Relations Director
Cottage Hospital
Grosse Pointe Farms, 48236

'Many of us sit by the fire and read your excellent journal'

Your continuing quality of production of the issues of *Michigan Medicine* is a great pride to every MSMS member, and as each new issue comes out I promise I will communicate my feelings and the feelings of my fellow Lenawee County Medical Society physicians to you. Congratulations!

I've thought sometime if you want to ever write some interesting articles about some of Michigan's unusual and some outstanding physicians' activities, you could focus upon those Physicians who are giving so much of their time and effort to teach the 'new brand' of Cardio-Pulmonary Resuscitation — the *Advanced Cardiac Life Support* courses in the State.

Then sometime consider an article about physicians like our Carl Benz, MD, Adrian ophthalmologist, who was joined in his practice by his son Steve about two years ago. To see this father-son partnership in action, saving eyes through the operating microscope or patients in their office and hearing them rave about the good feeling it gives them of trust and confidence to be working together is heart-warming.

These are just some random thoughts of outstanding medical people doing outstanding jobs that are extremely interesting to many of us who sit by the fire and read your excellent journal.

Richard D. Coak, MD
Adrian

MM article wins a first place

Thought you might be interested to learn that the Michigan Women's Press Club annual communications awards were given recently in Kalamazoo.

Of the four first places I won, one was for the *Michigan Medicine* article about Frank M. Ochberg, MD, from the December, 1979, issue (Entered as an interview, any-all circulations.). The judge, from *Fayetteville Times*, North Carolina, wrote: "It was judged on completeness and clarity.

After reading the piece I felt I knew Doctor Ochberg and wanted to know more about him. Although I'm sure space was a problem, I wanted to know about his experience with terrorist groups." The article goes on now to the National Federation of Press Women's Communication contest . . . will let you know how it fares there.

Willah Weddon
Stockbridge

Doctor Stawski thanks MSMS

I have just received a response from Mr. Drost of the Medicaid Information Division with regard to the recent problem which I have experienced with Medicaid billing.

I appreciate your interest and the cooperation of the Michigan State Medical Society in resolving this problem.

Willard S. Stawski, MD
Grand Rapids

MSMS staff frequently assists members with questions involving Medicaid billings.

Mrs. Weddon is a frequent contributor to *Michigan Medicine*. An article describing Doctor Ochberg's experience with terrorist groups and his current knowledge of the condition of the American hostages in Iran appears on page 210.

START	ADJUST
2 mg to 10 mg 2x to 4x daily	

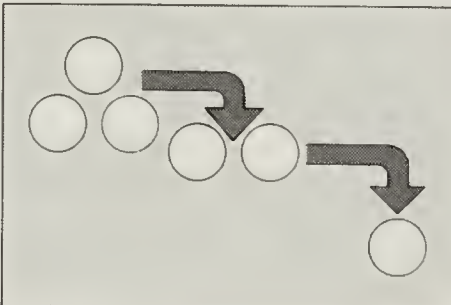
When anxiety fluctuates, as is common with most patients, the dosage may be adjusted as needed during the course of therapy; three strengths in scored tablets give you unmatched flexibility and simplicity in individualizing dosage.

SET GOALS						
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30	31		

Some physicians find that compiling a checklist of presenting symptoms and complaints is useful for assessing the patient's response from visit to visit. In this way, progress toward attainment of the therapeutic goal is reviewed at regular intervals. As patients feel their symptoms abate and begin to develop insight into the sources of their anxiety and psychic tension, the checklist can be expected to dwindle.

Intervention

When you decide to discontinue therapy, tapering dosage is good medical practice. Although rarely necessary after short-term treatment with Valium, gradual dosage reduction is advisable for patients who have been on extended therapy. This gradual discontinuance should preclude either recurrence of pretreatment symptoms or development of untoward side effects. Symptoms of withdrawal have almost always been associated with abrupt discontinuance of therapy at higher dosages taken continuously over long periods of time.



Valium® 2-mg, 5-mg, 10-mg scored tablets
diazepam/Roche

An Important Adjunct to Your Treatment Program for Excessive Anxiety



See the following page for a summary of product information.

Valium® (diazepam/Roche) ©

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety associated with anxiety disorders, transient situational disturbances and functional or organic disorders, psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal, adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, atetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

The effectiveness of Valium (diazepam/Roche) in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma, may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication, abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms similar to those with barbiturates and alcohol have been observed with abrupt discontinuation, usually limited to extended use and excessive doses. Infrequently milder withdrawal symptoms have been reported following abrupt discontinuation of benzodiazepines after continuous use, generally at higher therapeutic levels, for at least several months. After extended therapy, gradually taper dosage. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed, drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported. Should these occur, discontinue drug. Isolated reports of neutropenia, jaundice, periodic blood counts and liver function tests advisable during long-term therapy.

Dosage: Individualize for maximum beneficial effect. **Adults:** Tension, anxiety and psychoneurotic states, 2 to 10 mg b.i.d. to q.i.d. alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg i.i.d. or q.i.d. as needed, adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d., adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. **Geriatric or debilitated patients:** 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) **Children:** 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

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MSMS studying new CME opportunities for members

By Carl F. Hammerstrom, MD, Marquette



Physicians have a long tradition of intellectual curiosity and a willingness to learn. We are the profession which first assumed the responsibility for continuing to learn about what is new in our field.

If there is a criticism to be made of continuing medical education today it may be that there is so much that one can learn and so many "programs" available that the individual physician loses sight of any personal plan for educational growth. Physicians' decisions for learning seem to focus more upon which courses are available when the physician is "free for learning" than upon which skills are needed to meet patient care requirements or to correct a physician's perceived deficiencies.

Your committee has been frustrated in attempting to plan programs based on the usual "needs assessment" techniques of the past. Our experience with surveys of the perceived needs of MSMS members is that the act of being surveyed seems to prompt the members to correct the reported need before we can produce a program to "meet the need." We are convinced that the classical "course" or lecture is but one way to learn and are frustrated that most

category I educational offerings seem wedded to that one format.

Study has not yet documented that continuing educational activity by physicians improves patient care or professional competence. Nonetheless, your committee believes physicians participate in education exactly for those reasons and that the outcome is the improved competence of today's physicians as demonstrated by the improved care which our patients receive.

MSMS is committed to continuing education directed toward improved patient care. The limitations of proving a relationship of patient care process to improved outcome already have been demonstrated by the costly national experiment in utilization and peer reviews and patient care audits.

Your committee has a greater confidence that quality of care will be improved through the intellectual curiosity of the individual physician than by committees or educational institutions. Our discussions have focused on improving the physician's education by helping him or her be a better planner of a personal curriculum and on facilitating alternative learning experiences in addition to the traditional lecture course.

Floyd Pennington, PhD, and his colleagues at the University of Michigan's Office of Continuing Medical Education have presented the committee with a view of how a physi-

cian's personal learning plan could become "documentable" and thereby accredited.

We would welcome a system which would promote a physician's skills in assessing personal educational needs and assist the physician in assuring that the new information is applied in practice.

The assumption that this would improve patient outcome could be tested by helping physicians to develop skills in evaluating outcomes and recording them in ways which would allow a cumulative and ongoing analysis of individual practice.

The continuing education programming committee, in recognition of the turmoil in continuing medical education nationwide, has called for the establishment of a new MSMS Committee on Medical Education Policy to:

- 1) Identify those issues in continuing medical education felt to be critical for the physicians of Michigan.

- 2) Formulate policies concerning CME that would facilitate MSMS responses to these as well as future issues in CME; and

- 3) Make recommendations regarding CME activities for the future.

We hope that a new charge from the MSMS Council would direct the CME Programming Committee to implement some of the possibilities presented by the authors of this special report on CME activities.

Doctor Hammerstrom is chairman, MSMS Committee on CME Programming.

How MSMS CME programming has matured

By Herbert A. Auer, East Lansing

The state legislation mandating continuing medical education for physicians came at a time when leaders of MSMS, the medical schools, specialty societies, and hospitals were beginning to add more depth to their programs, workshops, seminars and conferences.

It is easy to say the state law is responsible for the higher quality now of MSMS continuing medical education, but that conclusion cannot be made so simply.

The old pattern at the MSMS Annual Scientific Meetings and other educational conferences around the state provided a smattering of unrelated topics with little or no concern about educational objectives. Speakers formerly had 20 minutes to blow-in, blow-hot and blow-out.

Today's meeting

Now, the MSMS Annual Scientific Meeting is planned by a Task Force which carefully reviews statistical information obtained from the most recent meeting. The Task Force knows which subjects draw well, which speakers are highly regarded, which topics meet the expectations of the listeners.

Now, the annual meeting program provides a wide variety of half-day programs on many topics, so interested physicians need not waste their time listening to speakers on

topics that will not help them in their daily practice.

By allotting three hours for a course, the course directors can provide considerable information and/or several points of view rather than skimming the top of a subject for 20 minutes, as was common 10 to 20 years ago.

The organization of the MSMS Annual Scientific Meeting Task Force is a positive step forward. The committee structure over the years in the past worked quite well, and some tremendous meetings were actually the work of one physician as the chairman.

Now, there is a Task Force of four to seven physicians representing different interests and these doctors provide the leadership. MSMS is wise to accept a practice whereby the chairman of the next Annual Scientific Meeting will be chosen from the membership of the Task Force. This will assure continuity.

The MSMS staff has done a tremendous job in developing procedures to handle the volume of correspondence needed in planning the conference, in preparing handouts for the course participants, in handling the audio-visual needs, in operating an efficient registration approach, etc. Each year, small improvements are made based on the last annual meeting so soon the project will be nearly perfect. Staff continuity is enhanced.

Some observations

One of my personal recommendations is that MSMS and the Annual Scientific Meeting Task Force might consider increasing the tuition by \$1 or \$2 per credit hour to build upon the information given out at a course. MSMS could pull together scientific

articles and bibliographies, on specific subjects so a mailing could be made 30-45 days after the meeting to the doctors enrolled in the various courses. In my opinion, MSMS should mail pertinent materials for study to doctors registering for courses two to four weeks before the course, or make a follow-up mailing afterwards.

As another personal observation, I wholeheartedly support the efforts of the task force to develop some "wet clinics" as part of some of the half-day courses. Hands-on demonstrations would enhance the assimilation of the verbal comments by the speakers.

In closing, as a former MSMS staffer responsible for CME activities, I commend Warren Tryloff and members of the MSMS Council for the support given to all those involved in the successful Annual Scientific Meetings. The half-day courses have been well designed and presented, and I am certain the members appreciate this quality membership-service project. I know the project requires endless hours of planning.

Mr. Auer formerly was deputy MSMS director in charge of communications and CME programming. He now is executive vice president of the Michigan Health Council and serves as a consultant to MSMS CME programming efforts.

Here's exactly what MSMS offers members in CME courses

By Sherry L. Fent, East Lansing



Former University of Michigan head trainer J. Lindsay McLean tapes a U-M athlete during a recent MSMS Sports Medicine Conference.

The enactment of legislation requiring continuing medical education for relicensure of Michigan physicians presented MSMS with new challenges. The medical society leadership identified CME programming as a major work area in late 1975 and by early 1976 had appointed a new Committee on Continuing Medical Education Programming.

The Committee's charge was "providing CME opportunities across the state for all physicians." The Committee members include practicing physicians, directors of medical education and knowledgeable education consultants. The CME Programming Committee applied to the MSMS Committee on CME Accreditation and was approved to present programs for Category I CME credit,

Mrs. Fent is MSMS Coordinator of CME Programming.

as well as to co-sponsor such programs with other unaccredited groups.

The CME Programming Committee is responsible for the certification of three MSMS annual meetings, and co-sponsors many others during the year.

Annual Scientific Meeting

The Annual Scientific Meeting has been presented for 114 years and began to use the present half-day course format in 1976, when MSMS also started to grant Category I credit for courses. In the last two years, a Task Force has developed the ASM courses and placed a great deal of emphasis on methods of teaching and quality of speakers.

More emphasis now is placed on methods by which the audience can participate or have a "hands-on" experience. Some examples include sports-medicine, where participants can learn taping procedures; oph-

thalmologic examinations utilizing models and scopes; and the neurologic exam, where procedures can be demonstrated on a patient.

It has been established that about half of the audience at the ASM is made up of family physicians, and for this reason, the Task Force now also tries to organize all courses to meet the criteria of the American Academy of Family Physicians for Prescribed Credit for family doctors.

The ASM Task Force is always striving for excellence in subject matter through needs assessments and for future topics through the evaluations. Attendance at the Annual Scientific Meeting has remained at the same level for three years, even in the face of a great deal of CME offerings in degrees of sophistication at the state, hospital, county and medical school level. An average of 1,500 doctors attend the ASM every year for a total of over 9,000 credit hours, or about 6.1 hours per physician. The Task Force is dedicated to continuing this tradition of excellence in education.

Maternal Health Conference

MSMS, for 19 years has presented the Annual Conference on Maternal and Perinatal Health. It too continues to draw a large audience of physicians, nurses, physicians' assistants, and other paramedical personnel.

Each year, the planning committee for the Conference strives to present new and updated information in the field of maternal and child health. Subjects over the last several years have included new techniques of ultrasonography, new findings about old childhood diseases and some controversial topics, such as abortion and amniocentesis.

For the last several years, MSMS has approved the two-day Conference for 11 hours of Category I Credit. The Michigan Academy of Family Physicians approves the Conference for AAFP Prescribed Credit, and nurses who attend the conference also are able to earn continuing education units, granted by the Michigan Nurses Association.

The Maternal and Perinatal Health Conference is an excellent example of the blending of subjects for a mixed audience which has proved to be a valuable educational experience for everyone.

Sports Medicine Conference

The MSMS Committee on Sports Medicine has organized a one-day conference annually in the spring for 14 years. The conference traditionally attracts about 300 physicians, coaches, and trainers from all parts of Michigan.

Presented in cooperation with the Athletic Trainers Society and the Michigan High School Athletic Association, MSMS has been joined in certification efforts by the Michigan Academy of Family Physicians and now grants 6 hours of Category I Credit as well as AAFP Prescribed Credit for the Conference. The subject matter has changed some in recent years from traditional organized sports such as football and basketball, to the treatment of such modern matters as "jogger's injuries."

The Sports Medicine Conference is another fine example of educational efforts for the health care team.

MSMS co-sponsorship

In addition to its traditional annual meetings, MSMS now co-sponsors programs with other organizations. In most cases, these groups or-



MSMS CME meetings, which have featured the traditional lecture presentation, are moving into new teaching methods involving the audience.

ganize continuing medical education programs at least once or twice throughout the year which are presented at many different locations across the state.

The MSMS Committee on CME Programming has established a procedure for co-sponsorship which has been better planned and refined over a period of several years.

Organizations which seek co-sponsorship are asked to apply 120 days in advance of their meetings in order to ensure committee contributions to the educational aspects of the programs. A great deal of attention is paid to the objectives for physicians.

The Committee stresses that objectives should describe physician behavioral changes which in turn affect patient care. The organizations must use an approved evaluation form and attendance-reporting procedure. MSMS will not assume any

financial obligation for these groups, but will provide staff assistance.

The Committee on CME Programming generally prefers to co-sponsor programs with groups on a continuing basis or where a relationship can be established to provide for the presentation of future CME conferences.

In the last two years, the Committee has co-sponsored over a dozen programs with eight different organizations on such varied subjects as allergy, treatment of the neonate, venereal disease and legal and ethical aspects of treating the critically/terminally ill.

The MSMS Committee on CME Programming has as its goals to continue to provide CME programs which reflect physicians' needs, which offer quality educational opportunities and are readily accessible to as many physicians as possible.

MSMS Annual Scientific Meeting builds on previous years' evaluations

The 1979 MSMS Annual Scientific Meeting, held at the Hyatt Regency in Dearborn, had 2,126 registered participants in attendance.

There were 1,540 MDs who attended the three-day schedule of Category I CME courses. There were 9,416 Category I credit hours awarded this year, as opposed to 9,000 in 1977.

Among the 57 half-day courses offered, those most popular dealt with occupational problems, diseases of the musculoskeletal system and connective tissue, mental disorders, geriatric problems, preventive medicine, and diseases of the respiratory system.

The professional and personal relevance of the material was the major reason given by physicians and others for attending the conference. Other reasons were reasonable cost, good location, featured specialty, necessary Category I credit offered, and a particular speaker.

The MSMS coordinators of this annual event work year-round to present significant topics by the most qualified practitioners. An evaluation procedure following each conference facilitates this effort for improvement and quality.

One hundred and sixty-two participants of the 1979 event completed forms and were helpful in determining the strengths and weaknesses of the program. Those instructing the courses were evaluated on content and presentation, adequate answers to questions, visual aids, whether the listener's expectations were fulfilled, and whether the objectives of the class were defined and met.

The over-all result of the questionnaires was favorable, encouraging, and complimentary. Ninety percent said they achieved personal goals, 72.5 percent said there were adequate learner-teacher reactions, and 75 percent felt the course had the correct amount of technical content.

Dissatisfaction appeared in the delivery of the material such as the length or speed of the presentation, need for more clarification of terms, more demonstrations, and improvement in the physical aspects of the room used, such as the size and temperature.

In addition to the evaluation procedure, participants also were asked what patient problems caused them the most concern and difficulty. Ninety-eight problem areas were identified and will be considered for course material in the future.

Drastic change

Over the last three years that this 114-year old event has taken place, the format for teaching has gone through drastic change.

The traditional lecture presentation of course material is now supplemented by "wet clinics" which allow participants an active role in the learning process.

According to Samuel McMahon, MD, chairman of the MSMS Annual Scientific Meeting, "Participants are asked to apply what is taught. This practical application forces them to think about the material presented and also gives them the opportunity to ask questions. This participatory format is an effective learning experience which allows individuals to leave with the knowledge they sought to gain."

The significance of this new concept in learning is demonstrated in the high registration figures for such a course. Because of this, early registration is encouraged to insure all those interested have the opportunity to participate.

Also new to the Annual Scientific Meeting format is the alpha-omega session, which emphasizes the breadth of a given disease rather than the depth. These courses examine a particular disease in age

groups ranging from the infant to the elderly and the considerations made when prescribing treatment. The alpha-omega concept is a possible consideration for areas such as depression.

Doctor McMahon feels, "There is a growing interest in the interpretation of laboratory and research data and diagnosis which deserves more attention in future meetings. One well-received course which accommodated this interest in 1979 offered participants training in reading and interpreting EKGs."

In addition to technical courses of professional interest, other courses concerned with interpersonal communication which affect practitioners, are also offered.

'Repeat this course'

In 1979, Rodman C. Jacobi, MD, associate professor in the Department of Family Practice at Michigan State University, attended such a course on stresses within the physician's family.

His evaluation was as follows: "It was a very worthwhile area of doctor education and the format was good. However, those attending might have been more willing to participate and ventilate if the group was broken down into smaller groups after the major presentation. Objectives and orientative comments are needed initially for guiding the process. Repeat this course."

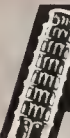
Responses such as these are the basis for coordinating and implementing next year's program. The program's task force uses this information along with its educational expertise in determining topic choices and instructors. Together with the program's administrative committee at MSMS, the Annual Scientific Meeting Task Force continues to work for a rewarding and enlightening experience for those participating.

DESCRIPTION: Methyltestosterone is 17 β -Hydroxy-17-Methylandrosta-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunichism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-puberal cryptorchidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric,

avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE**

REACTIONS: Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. **In the male:** Eunuchoidism and eunuchism, 10 to 40 mg. Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg. Postpuberal cryptorchism, 30 mg. **REFERENCE:** R. B. Greenblatt, M.D., R. Witherington, M.D., I. B. Sipahoglu, M.D. Hormones for Improved Sexuality in the Male and the Female Climacteric. *Drug Therapy*, Sept. 1976. **SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only

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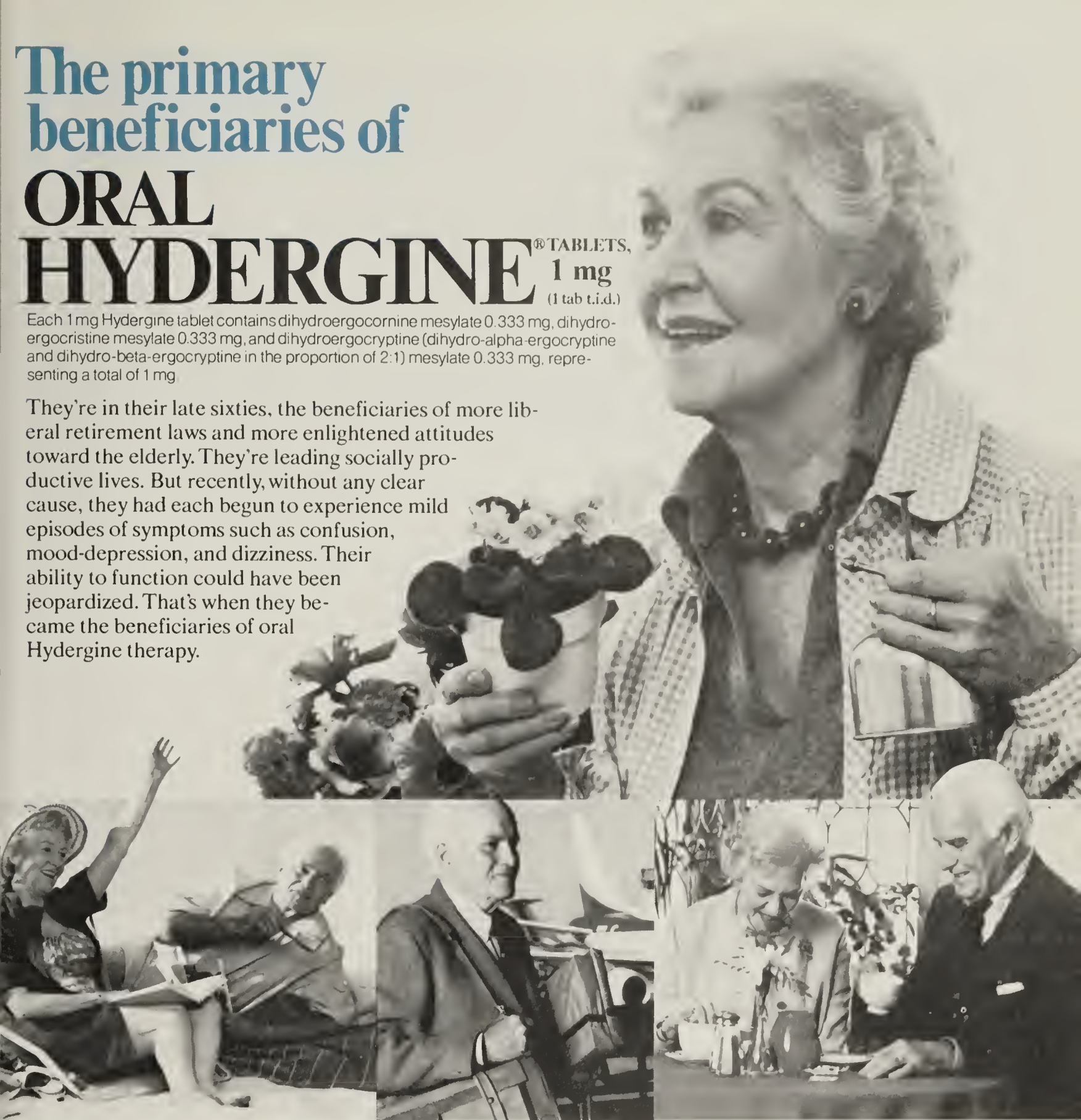
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Medicaid Surveillance system keeps close watch on MD payments

By Giovannino A. Perri, MD, Lansing

The Medicaid Program has received valuable support from the Professional/Technical Peer Review Group for Doctors of Medicine in its efforts to ensure that quality care is provided Medicaid recipients.

The physicians who serve on the committee are peers in the legal sense that they are "equal under the law" in order to review other physicians' practices, and also in that they "peer" (look intently, searchingly, in trying to see more clearly) into the standard of care received by patients.

In so doing, this group is a valued resource from the physician community to a government program that pays well over \$100,000,000 annually to Michigan physicians.

The committee serves as a substantial deterrent to those few physicians who would abuse the health care system for personal gain.

The Medical Assistance Program (Medicaid) has developed continuing peer review system to monitor the quality of care received by Medicaid recipients.

The Michigan State Medical Society assisted the Department of Social Services (MDSS) in establishing a Professional/Technical Peer Review Group for Doctors of Medicine as part of this peer review system. That group is actively reviewing cases involving some physicians who receive payments for services from Medicaid.

In early 1977, MSMS assisted the state in establishing this committee. The state used committee format suggested by MSMS: a core structure of family physicians, pediatricians, and internists, and advisory specialists from among the medical and surgical specialties. MSMS also shared with the Department of Public Health (MDPH) the composition of its Medical Audit Committee and submitted nominations to fill the various committee posts. From this list of MSMS

nominees, appointments were made, to the Professional/Technical Peer Review Group for Doctors of Medicine.

The committee chairman is Pat Crow, MD, of the Family Practice Center at Sparrow Hospital in Lansing. The group includes Jerome Cordes, MD, Lansing; Harry C. George, MD, East Lansing; Henry A. Kallet, MD, Chelsea; Philip Lange, MD, H. James McCoy, MD, Robert F. Thimmig, MD, and Douglas F. Wacker, MD, all of Lansing.

These members are practicing physicians, board certified in their respective specialty areas, and have generously volunteered their time and expertise since the committee's formation in 1977.

To date, the committee has held nine meetings. The group met with representatives from MDPH three times in 1977. In the spring of 1978, however, a reorganization of the State departments units administering of the Medicaid Program resulted in a transfer of the Surveillance and Utilization review work to the Department of Social Services.

No committee meetings were scheduled pending the completion of this reorganization. The group reconvened in January 1979 and has met six times in the last 12 months.

Doctor Perri is medical consultant, Bureau of Health Services Review, Medical Services Administration, Michigan Department of Social Services.

22 physicians reviewed

The committee has reviewed Medicaid reimbursements to 22 physicians. In 16 cases, the group concluded the care rendered was inappropriate to the needs of the patients, based on information in the medical records and the patterns of practice. Looked at in economic terms, the peer review committee has reviewed cases representing payments of \$1,377,470 to those 22 physicians, and has concluded that over half of those payments involved inappropriate and unnecessary services.

The typical case brought before the peer review committee consists of a summary of approximately 100 patient records picked at random, covering services during a specified one-year time period. The most common issues found in these audits include overuse of clinical laboratory testing, inappropriate use of injectable medications, and less than acceptable modes of therapy for a given disease. Some examples from different cases will highlight the problems encountered while reviewing care paid for by public money:

A six-year-old boy, known previously to the physician being reviewed, was seen with a temperature of 102.6°F (0) and complaints of a sore throat for one day. Exam revealed cervical lymphadenopathy, enlarged tonsils, and a question of enlarged thyroid gland.

Medicaid was billed for the office visit and the following: BUN, glucose, cholesterol, total protein, albumin, bilirubin, LDH, SGOT, alkaline phosphatase, phosphorus, uric acid, protein electrophoresis, thyroglobulin, febrile agglutinins, serum iron, iron binding capacity, vitamin B12 level, folate level, T₃, T₄, electrolytes, complete blood count, ESR, sedimentation rate, reticulocyte count, platelet count.

No throat culture was obtained. The child was treated with injections of procaine penicillin and chlorpheniramine, and was given a prescription for erythromycin. (The cost to Medicaid for these services: \$230.)

continued on page 190

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before treatment. If an allergic reaction occurs, discontinue the drug and treat with the usual agents (e.g., epinephrine or other pressor amines, antihistamines, or corticosteroids).

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Adverse Reactions: Hypersensitivity, including fatal anaphylaxis. Nausea, vomiting, epigastric distress, diarrhea, and black, hairy tongue. Skin eruptions, urticaria, reactions resembling serum sickness (including chills, edema, arthralgia, prostration), laryngeal edema, fever, and eosinophilia. Infrequent hemolytic anemia, leukopenia, thrombocytopenia, neuropathy, and nephropathy, usually with high doses of parenteral penicillin. (102175)

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SURVEILLANCE/continued

The 18- and 16-year old sons of a 40-year-old male patient known to a cardiologist were seen by that physician for the first time. The physical examinations revealed no abnormalities. Yet both sons received the following diagnostic tests — glucose, BUN, uric acid, T₃, T₄, cholesterol, total protein, lipids, chest Xrays, pulmonary function testing, vectorcardiogram, exercise ECG, phonocardiogram, and Holter 24 hour cardiac monitoring — in conjunction with their visit.

No established or suspected familial heart disease had been noted and the only symptomatology elicited on history from these young men were occasional fatigue in one and occasional "palpitations" in the other. (The cost to Medicaid for these two visits: \$725.10.)

A nine-year-old boy was seen for the first time by a family physician. He presented with a history of a laceration to his foot three days before the visit; the remainder of the history was noncontributory.

Examination revealed a temperature of 99.4°F and "congested" pharynx. The physician ordered the following: throat culture, urinalysis, urine culture, electrolytes, bilirubin, albumin, calcium, cholesterol, creatinine, LDH, alkaline phosphatase, glucose, phosphorus, SGOT, SGPT, BUN, complete blood count, sedimentation rate, serologic test for syphilis, immunoglobulin levels, serum cortisol, lipoprotein phenotyping, radioimmunoassays for vitamin B12, folate, T₃, T₄, TSH, and pulmonary function tests. The physician wrote that he debrided the wound on the foot and the child was sent home. (The cost to Medicaid for that visit and testing: \$514.15.)

MDSS seeking recovery

The Department of Social Services now is pursuing recovery of those payments for services judged to be not medically necessary by the peer review committee.

The Medicaid Program has, however, not yet been able to realize these recoveries because most of the cases reviewed are at one or another stage of an appeal filed by the physician involved.

There are administrative rules which must be adhered to before MDSS can take a negative action such as recovering money or disenrolling a provider from participation in Medicaid. These rules call for informal conferences, followed by formal hearings before an administrative judge, and finally, appeal to the court system.

The legislature has recognized the effectiveness of the peer review committees and has taken steps to ease the Medicaid Program's ability to follow up on peer review recommendations. The Department of Social Services Appropriations Act, Public Act 110 of 1979, effective October 1979, states in Section 32(2):

"(2) The department of social services may withhold or suspend payments to a provider of medical services for medical care related to title 19 of the social security act, 42 USC 1936 to 1396k, in cases in which an audit by the department of social services or public health indicates potential fraud, or in cases of abuse, as certified by the applicable peer review committee, the amount of withholding shall be in direct relationship to the amount of overpayment projected by the department. The amount shall be held in escrow pending resolution of the problem."

Also, the same legal system which protects the due process of law of the physicians being investigated, protects the members of the committee from liability for acting in good faith to review their peers.

PA 119 of 1975 as amended (a copy of which was reproduced in the August 1979 *Michigan Medicine*) states, "liability of any kind shall not arise or be enforced against any person, organization, or entity by reason of having provided such information or data; by reason of any act or communication within its scope as a review entity; or by reason of having released or published the proceedings, reports, findings or conclusion of the review entity . . ."

By making members immune from libel or slander accusations, this law permits the kind of frank discussion and critical evaluation necessary to effectively evaluate a physician's practice.

Surveillance utilization review

As stated earlier, the concept of peer review was first utilized by MDSS and MDPH in 1977 in conjunction with another feature of the Medicaid Program. HEW had, at that time, developed the Medicaid Management System, to assist states in administering their Medical Assistance Programs more efficiently and with more accountability. One component of that system called for a series of computer programs entitled "Surveillance and Utilization Review" (S/UR), to be established.

By using S/UR, Medicaid can analyze information from the Medicaid invoices and from enrollment files, and generate reports which compare a given physician's pattern of practice with the practice pattern of other physicians in the same geographical area and of similar declared specialty. The data point out, as in the examples above, that family physician Doctor X may order six times the number of laboratory tests per Medicaid patient as other family physicians seeing Medicaid patients. These reports are then analyzed for accuracy and for their possible implications as to the appropriateness of care being rendered.

When questions persist about the patterns of care, such as use of laboratory services described above, the Medicaid Program can obtain access to the physician's medical records. Medicaid can audit these records. That is, the information contained in the records is compared to the payments made to that physician on behalf of those patients. Such a medical record review is performed first by a nurse familiar with Medicaid policy, procedures and coding, and then by a physician.

It is at this point in the audits that the peer review committee becomes involved. The physicians on the committee review these audited cases in detail, studying medical records and the reports of the initial program reviewers. Following such study, the committee votes on motions which summarize their impressions of the case and which give the Department of Social Services the group's recommendations.



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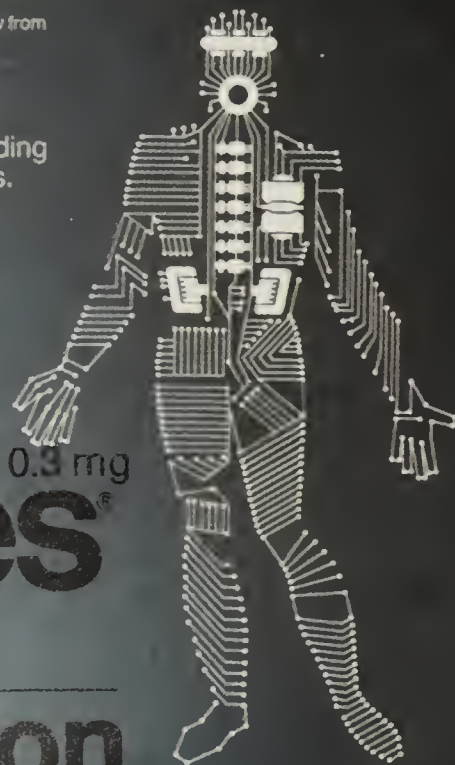
*Central alpha-adrenergic stimulation decreases sympathetic outflow from the brain, as shown in animal studies.

1. Data on file at Boehringer Ingelheim Ltd.

Please see last page for brief summary, including warnings, precautions, and adverse reactions.

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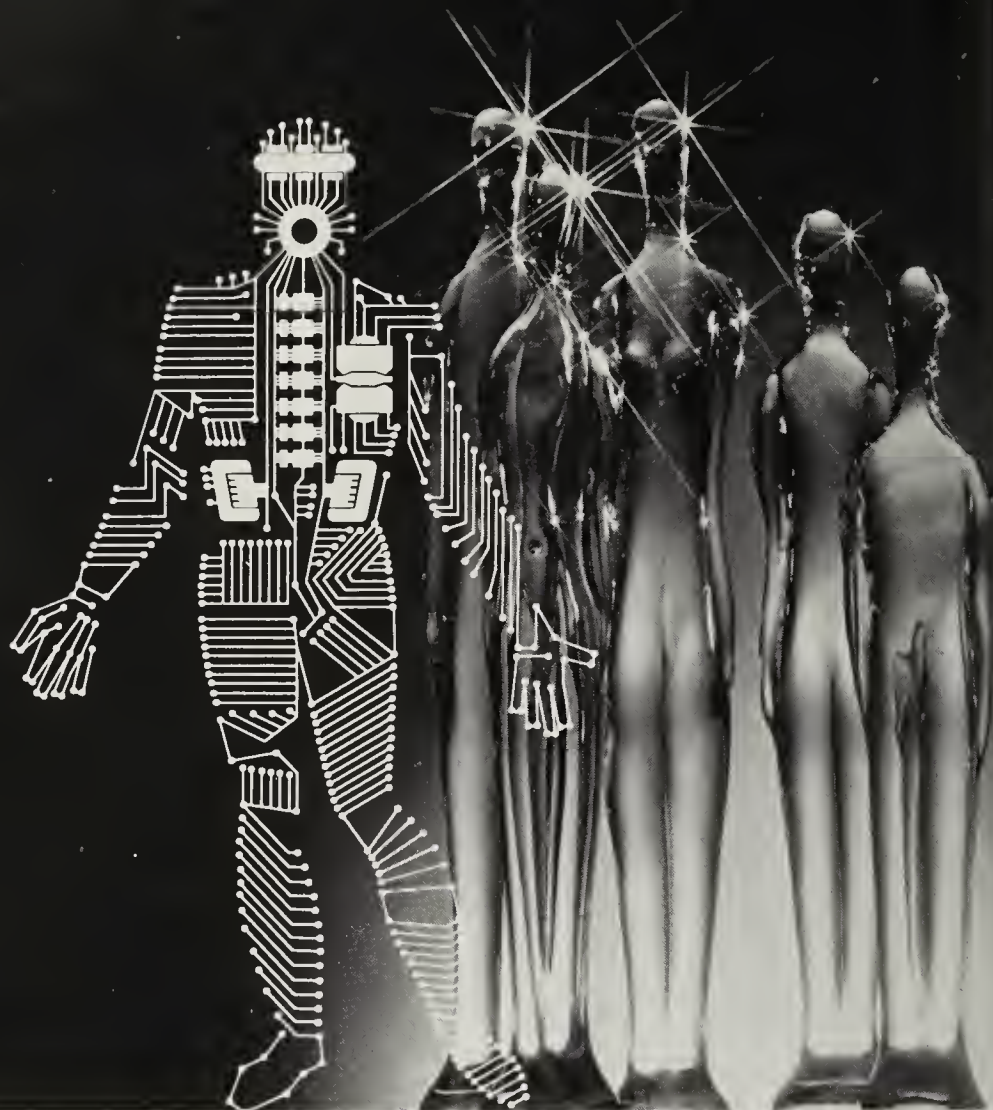
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Indication: The drug is indicated in the treatment of hypertension. As an anti-hypertensive drug, Catapres (clonidine hydrochloride) is mild to moderate in potency. It may be employed in a general treatment program with a diuretic and/or other antihypertensive agents as needed for proper patient response.

Warnings: Tolerance may develop in some patients necessitating a reevaluation of therapy.

Usage in Pregnancy: In view of embryotoxic findings in animals, and since information on possible adverse effects in pregnant women is limited to uncontrolled clinical data, the drug is not recommended in women who are or may become pregnant unless the potential benefits outweigh the potential risk to mother and fetus.

Usage in Children: No clinical experience is available with the use of Catapres (clonidine hydrochloride) in children.

Precautions: When discontinuing Catapres (clonidine hydrochloride), reduce the dose gradually over 2 to 4 days to avoid a possible rapid rise in blood pressure and associated subjective symptoms such as nervousness, agitation, and headache. Patients should be instructed not to discontinue therapy without consulting their physician. Rare instances of hypertensive encephalopathy and death have been recorded after cessation of clonidine hydrochloride therapy. A causal relationship has not been established in these cases. It has been demonstrated that an excessive rise in blood pressure, should it occur, can be reversed by resumption of clonidine hydrochloride therapy or by intravenous phentolamine. Patients who engage in potentially hazardous activities, such as operating machinery or driving, should be advised of the sedative effect. This drug may enhance the CNS-depressive effects of alcohol, barbiturates and other sedatives. Like any other agent lowering blood pressure, clonidine hydrochloride should be used with caution in patients with severe coronary insufficiency, recent myocardial infarction, cerebrovascular disease or chronic renal failure.

As an integral part of their overall long-term care, patients treated with Catapres (clonidine hydrochloride) should receive periodic eye examinations. While, except for some dryness of the eyes, no drug-related abnormal ophthalmologic findings have been recorded with Catapres (clonidine hydrochloride), in several studies the drug produced a dose-dependent increase in the incidence and severity of

The usual starting dose of Catapres is 0.1 mg at breakfast and 0.1 mg at bedtime. Some patients may benefit from a starting dose of 0.1 mg at bedtime.

Usual daily dose range—0.2 — 0.8 mg

Maximum daily dose—2.4 mg
Doses as high as this have rarely been employed.

For optimal results, the dose of Catapres must be adjusted according to the patient's individual blood pressure response.

spontaneously occurring retinal degeneration in albino rats treated for 6 months or longer.

Adverse Reactions: The most common reactions are dry mouth, drowsiness and sedation. Constipation, dizziness, headache, and fatigue have been reported. Generally these effects tend to diminish with continued therapy. The following reactions have been associated with the drug, some of them rarely. (In some instances an exact causal relationship has not been established.) These include: Anorexia, malaise, nausea, vomiting, parotid pain, mild transient abnormalities in liver function tests; one report of possible drug-induced hepatitis without icterus; and hyperbilirubinemia in a patient receiving clonidine hydrochloride, chloralhydrate and papaverine hydrochloride. Weight gain, transient elevation of blood glucose, or serum creatine phosphokinase; congestive heart failure, Raynaud's phenomenon; vivid dreams or nightmares, insomnia, other behavioral changes; nervousness, restlessness, anxiety and mental depression. Also rash, an angioneurotic edema, hives, urticaria, thinning of the hair, pruritus not associated with a rash, impotence, urinary retention, increased sensitivity to alcohol, dryness itching or burning of the eyes, dryness of the nasal mucosa, pallor, gynecomastia, weakly positive Coombs' test, asymptomatic electrocardiographic abnormalities manifested as Wenckebach period or ventricular trigeminy.

Overdosage: Profound hypotension, weakness, somnolence, diminished or absent reflexes and vomiting followed the accidental ingestion of Catapres (clonidine hydrochloride) by several children from 19 months to 5 years of age. Gastric lavage and administration of an analeptic and vasopressor led to complete recovery within 24 hours. Tolazoline in intravenous doses of 10 mg at 30-minute intervals usually abolishes all effects of Catapres, (clonidine hydrochloride) over dosage.

How Supplied: Catapres, brand of clonidine hydrochloride, is available as 0.1 mg (tan) and 0.2 mg (orange) oval, single-scored tablets in bottles of 100 and 1000. Also available as 0.3 mg (peach) oval, single-scored tablets in bottles of 100.

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Michigan's government and you, doctor

The Michigan Department of Licensing and Regulation

By Gary W. Anderson, East Lansing, staff, MSMS Liaison Committee to Board of Medicine

Part five of a series to help Michigan physicians better understand the relationship of state government to medical practice.

Following adoption of the 1963 Michigan Constitution and the Executive Reorganization Act of 1965, the Department of Licensing and Regulation was created as an umbrella agency to oversee the licensing and disciplinary boards which regulate various professions.

The Department's chief objective is to protect the health, welfare, and safety of Michigan citizens by requiring high standards and competence of those who are given the right to practice in certain occupations or professions by issuance of a state license, registration or certificate.

The Michigan Board of Medicine is one such board under the jurisdiction of the Department of Licensing and Regulation.

On a monthly basis, the Board of Medicine, which consists of 14 members (10 MDs, three public members, and one physician assistant) meets to take action on a variety of concerns. These concerns range from determining the standards of practice, to drafting rules on mandated CME, to taking disciplinary actions against physicians' licenses.

Code changes

Prior to the enactment of the Public Health Code in 1978, the Board of Medicine functioned relatively autonomously, using only the support service of the department.

Since the enactment of the Code, several board functions have been transferred to the department. An example is the shift of the complaint analysis and investigation functions to the department, away from the control and supervision of the Board. Another major change within the Department of Licensing and Regulation as a result of the enactment of the Public Health Code is the creation of the Health Occupations Council.

This 30-member consumer-dominated board comes under the jurisdiction of the Department of Licensing and Regulation and derives its administrative and support services from it. The purpose of the Health Occupations Council is to evaluate proposals for the licensure and registration of existing and emerging health occupations. The HOC recommends to the department, other state agencies and the legislature the appropriateness of, and the mechanisms for, regulating those health occupations. The Health Occupations Council currently is assessing its own role in the health care field, and is attempting to review and comment on all rules and legislation regarding health professions. In effect, the Health Occupations Council functions as legislatively-mandated consumer review, with minority provider input, on the delivery of health care in Michigan.

MSMS traditionally has maintained liaison with the Board of Medicine to support issues of mutual concern and resolve issues of disagreement. As a result of shifting responsibilities created with the pas-

sage of the Public Health Code and the establishment of the Health Occupations Council, MSMS has expanded its emphasis on the Liaison Committee with the Board of Medicine. In addition MSMS is attempting to increase its efforts to provide input into the policy formulation of the parent agency, the Department of Licensing and Regulation.

In his January, 1980, State of the State address, Governor Milliken called for further reorganization of state government.

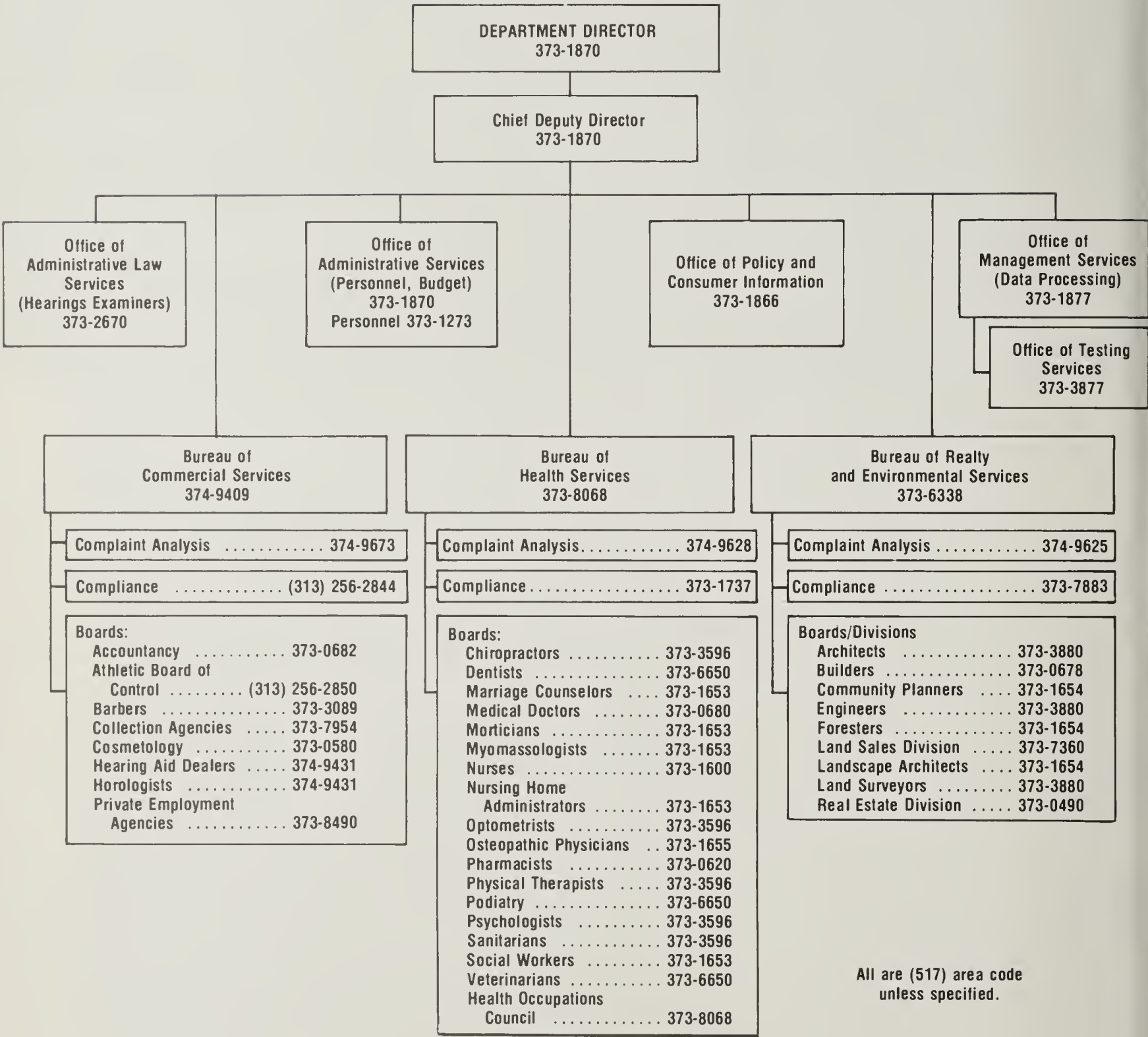
He recommended transferring the activities of the Liquor Control Commission and the Insurance Bureau from the Department of Commerce to the Department of Licensing and Regulation.

Legislation to this end has been introduced, with the justification that the activities of the Liquor Control Commission and the Insurance Bureau are regulatory in nature, and therefore, are more appropriately under the jurisdiction of the Department of Licensing and Regulation.

Presently L and R is one of the state's smallest departments with some 250 employees and a budget of \$8.4 million. If enacted into law, this reorganization will make the Department of Licensing and Regulation responsible for \$51 million in state funds and 1,400-1,600 state employees.

On the next page is an organizational chart of the Bureaus, Boards, and Divisions under the purview of the Department of Licensing and Regulation.

ORGANIZATIONAL CHART:
MICHIGAN DEPARTMENT OF
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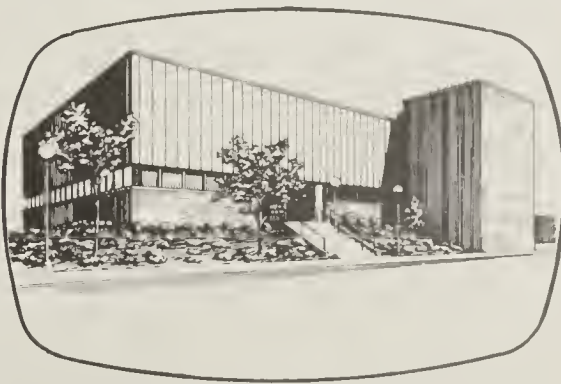
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Immunization requirements more stringent under new Michigan Public Health Code

by William F. Simonsen, SrPHA



Children attending schools and day care facilities are subject to immunization requirements which are more complex and which will be more rigorously enforced during this year and the years to come.

Statements which used to be accepted by school officials from family physicians such as "complete" and "up-to-date" are now dismissed out of hand.

In order to avoid confusing and inconveniencing their patients, physicians should become familiar with the new jargon and requirements.

Certificate of immunization

Part 92 of the Public Health Code requires a health care provider to present a certificate of immunization or make an entry thereof on a certificate in the person's possession whenever a vaccine is administered. Parents are obliged to present such a certificate to school or day care officials at the time a child is first enrolled. The required certificate can be any of a variety of personal health records or family immunization cards provided that dates can be listed adjacent to each dose of vaccine given in the series. The record becomes certified when signed by the provider.

The state health department is currently developing a standard immunization record which will soon be widely distributed. While the use of this new record will be encouraged, other forms will continue to be accepted provided that the essential information is contained.

Medical exemption

Children who have health reasons for not being able to safely receive vaccines can be waived from the immunization requirements upon a written notice from their family

physician. While an official form for this purpose is available at schools and local health departments, a simple note on a physician's stationery also will be accepted.

The essential elements which must be included are: 1) A listing of each vaccine contraindicated; 2) the time period during which the exemption shall remain in effect; and 3) the true signature of the practicing medical or osteopathic physician. The reason for the exemption is also requested but it is not legally required.

Religious and other exemptions are also permitted under the law and these merely require a simple signed statement by the parent or guardian.

Many schools, especially those in our metro area, will still be reviewing records of immunization and noting deficiencies for older non-entrant students. For the most part, these students will be required to attain the immunization standards cited above for new students. The major exception is mumps which for economic reasons is not required for this catch-up program.

The initial search of school records, particularly senior and junior high schools, has revealed an alarming level of deficiencies. In some cases, only one child in four has had all the required immunizations. Many of these deficiencies may simply reflect the poor maintenance of records.

Since proof of immunizations is now being required, physicians' patience and cooperation in recertifying certain vaccine doses given years ago to some of your patients is urgently solicited.

With physicians' help, we will be better able to identify the children who really need additional vaccine doses and see that they get them before the next epidemic season.

Please see page 200 for table on immunizations.

Mr. Simonsen is coordinator of the Michigan Immunization Project of the Michigan Department of Public Health.

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IMMUNIZATION/continued

Specific immunization requirements

All children attending day care centers, all children in kindergarten, as well as all other children entering Michigan schools for the first time are subject to the following minimum immunization requirements:

a. **First day attendance:** In order to initially enroll and attend any school, each pupil must have a minimum of at least one dose of diphtheria and tetanus toxoids and pertussis vaccine, polio, measles, rubella and mumps vaccine. The pertussis vaccine requirement will be waived for children over six years of age.

b. **For continued enrollment:** During the first few weeks of a child's enrollment, his school health record will be carefully checked for immunization deficiencies against the immunization standards.

Most schools and local health departments have pre-set exclusion dates at which time students lacking parts of the required series are suspended from daily attendance. A week or two prior to the exclusion date, individual warning notices are sent to the parents specifying what records or shots must be received to continue the child's enrollment beyond the exclusion date.

The following criteria are used:

Four Diphtheria and tetanus toxoids and pertussis vaccine

A total of four doses must be received. These doses should be spaced at

least six weeks apart with the final dose given at least six months after the third dose. For children who are starting the entire series after age six years, only three doses will be required. The pertussis vaccine component is also waived for children after their sixth birthday. A reinforcing booster of Td(adult) is required for children over age 12 if no tetanus toxoids had been given during the preceding ten years.

Three Oral Polio Vaccine

Three doses of trivalent oral polio vaccine are required with the final dose given at least six months after the second dose. Inactivated polio vaccine (Salk type) may be substituted for TOPV provided that a final booster dose of TOPV is given. In the latter case, three IPV plus one TOPV or two IPV plus two TOPV must be given.

One Measles

One dose of a live, further attenuated measles vaccine or some combination containing live measles vaccine (i.e., MMR) must have been given on or after the child's first birthday anniversary. If the vaccine was originally given prior to the child's first birthday, it must be repeated. A physician-diagnosed history of disease can be accepted as meeting the measles immunization requirement but a parent's recall of measles illness is not accepted. The rules also permit a laboratory test to certify measles immunity but we do not recommend the test as a routine for determining whether measles vaccine should be given.

Some high school students also may be subject to these requirements. Those students who received their measles vac-

cine in 1966 or earlier are required to repeat the immunization because it may be impossible to determine whether killed or live vaccine was originally given. By the same token, vaccines given simultaneously with gamma globulin may have compromised the attainment of adequate immunity especially if too much GG was given with Edmundson strain vaccines or if any GG was given with the Schwartz strain (Lyrugen) vaccine.

One Rubella

One dose of live rubella virus vaccine or a combination containing live rubella vaccine must have been given on or after the child's first birthday. A history of rubella disease, even if diagnosed by a physician, is not an acceptable substitute for this requirement. For those older students who were immunized prior to July 1, 1969, (the approximate licensure date of the first rubella vaccine), the vaccine must be repeated. Again, a laboratory test for rubella showing HI or CF antibodies in sufficient concentration will be accepted as proof of immunity but we do not recommend the test as a routine for determining whether rubella vaccine should be given to most children.

One Mumps

One dose of mumps virus vaccine or a combination containing live mumps virus vaccine given after the child's first birthday is required for children who have entered or who will enter school after Sept. 1, 1979. Some schools and some county health departments require mumps vaccine for older children as well. A laboratory test is accepted as proof of immunity, but a history of mumps disease without the test is not accepted.

How the MSMS Auxiliary promotes immunizations

By Evelyn Dykewicz

In 1977 the AMA president requested the AMA-Auxiliary to join a nationwide HEW campaign to raise the immunization level of children under 15 from 63 percent to 90 percent by October 1979.

Current HEW Secretary Patricia Harris has asked for continued support of the Auxiliary in this endeavor until the 90 percent level is reached for the seven vaccine-preventable diseases and the establishment of a permanent mechanism to ensure the immunization of newborns.

In her 1979 letter to the AMA-Auxiliary president, Secretary Harris

Mrs. Dykewicz is MSMS Auxiliary Immunization Chairman.

stated that 91 percent of more than 24 million school children currently assessed in K-8 grades are now protected against measles, polio and DTP. Eighty-four percent of this group are protected against rubella.

Since Michigan accounted for nearly 30 percent of measles cases and 19 percent of rubella cases in 1978, an assessment program to identify children in grades 1-12, who are deficient in the number of all immunizations required, is currently in progress. Auxilians in Bay, Arenac, Iosco and Genesee counties have worked on the assessment program in the schools this past year; Macomb and Genesee Auxilians provided nurse volunteers and clerical help for the Catch-Up program; Muskegon

County distributed immunization material to K-3rd graders as did other counties; immunization films have been shown in classrooms and on TV stations. To keep the Auxiliary membership apprised of national and state trends, an MSMS Auxilian serves on the Immunization Action Committee of the Michigan Department of Public Health.

Secretary Harris commended Auxilians in saying, "As a result of your efforts, the upward trend in disease incidence has been reversed, and tens of thousands of youngsters have been spared the terrible effects of these once-common illnesses."

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Board of Medicine asking L and R for clear statement to end strife and tension

By Charles R. Downs, Special to Michigan Medicine



Board of Medicine President Donald H. Kuiper, MD, right, meets at MSMS headquarters with MSMS Department of Government Relations Manager Bruce W. Ambrose.

Michigan's new Public Health Code, which went into effect in October 1978, intentionally challenges the Board of Medicine (formerly the Medical Practice Board) with some tough assignments. These assignments will demand considerable creativity on the part of the 13 members of the Board and could lead to very significant improvements in medical practice in Michigan.

But, says Donald H. Kuiper, MD, the code also unintentionally has made it difficult for the Board of Medicine to accomplish routine investigations of charges against physicians, thus keeping the Board from attending to more far-reaching matters.

Doctor Kuiper, a Lansing gastroenterologist who recently succeeded John R. Wilson, MD, of Grand Rapids as president of the Board, is hopeful administrative problems soon will be worked out and the Board will be able to start promulgating rules in areas mandated by the Public Health Code.

Insuring competence

He says one of the most important areas is developing a system for

insuring continuing competence of physicians. The Public Health Code allows six years — just four and a half years from now — for that to take place.

This assignment is complicated by the fact that a licensed doctor is now legally — if not practically — able to practice in any given area of medicine, Doctor Kuiper notes.

"So, how can you insure competency in all the areas that a doctor is now licensed to practice?" he asks.

In his view, the best answer might be to license people to practice only within certain specialty areas — areas that would be broad enough to give a doctor the same general latitude that most doctors now work under (such as rules of hospitals, specialty groups), but narrow enough to make it feasible to test competency.

"I'd like to see the board adopt the standards of the respective American specialty boards," says Doctor Kuiper. "If, for example, I am recertified by the Board of Internal Medicine, that would be accepted by the Board as evidence of my competency."

Doctor Kuiper points out present specialty board requirements vary.

Some — family practice, for instance — require an examination every six years and others are working toward that kind of requirement.

"Licensing by specialty," he notes, "would not lock anyone into a given area. A person could even be licensed in more than one area or could go from one specialty to another."

"For example, someone who retired from educational administration could enter private practice in a specialty if he studied for and passed the appropriate examination."

Another weighty matter for the Board of Medicine is the development of rules on limited licensure. The Public Health Code provides for three types: (1) educational, for physicians in postgraduate training; (2) nonclinical, for physicians involved primarily with research or administration; and (3) clinical academic for physicians primarily involved with teaching.

Still another area that needs a set of comprehensive rules is delegation of medical functions to nonphysicians.

"At present," notes Doctor Kuiper, "a lot of procedures are being delegated and there are no rules to cover what is proper and what is not."

An additional area of particular concern to Doctor Kuiper is rules on the use of narcotics and tranquilizers.

"We have developed some very good rules for dealing with amphetamines," he says, "but this would be breaking new ground. There are definitely more narcotics and tranquilizers being prescribed than there need to be. We are going to have to come up with some good standards in order to get a consensus."

Administration dominates

At present, Doctor Kuiper finds himself spending too much time dealing with tensions resulting from administrative interpretations of the new code.

continued on page 204

These are the MDs on Michigan Board of Medicine

James C. Breneman, MD, Galesburg, is vice president of the Board of Medicine, and has served six years on the board. A certified member of the American Board of Allergy and Immunology, Doctor Breneman is former chairman of the Food Allergy Program of the American College of Allergists. Since 1974 he has served as the general chairman of the International Food Symposium. Doctor Breneman is the author of "Basics of Food Allergy," published by Charles C. Thomas of Springfield in 1978. He is the president and founder of Allergy-Immunology International.

John F. Fennessey, MD, Grosse Pointe, graduated from Tufts University and is a board-certified pathologist. A full-time specialist, Doctor Fennessey is affiliated with Doctor's Hospital and the Deaconess branch of the Samaritan Hospital. Doctor Fennessey recently was appointed provider member of the Comprehensive Health Planning Council of Southeastern Michigan, and to the CHPC-SEM's Detroit City Subarea Advisory Council for a term expiring 1982. A graduate of Wayne State University Law School, Doctor Fennessey also is a member of the Medical-Legal Committee for the Michigan State Bar. Doctor Fennessey is an associate professor of pathology at Wayne State University and is a fellow of the American Society of Clinical Pathologists and the College of American Pathologists.

James L. Fenton, MD, Bay City, is a board-certified specialist in radiology and roentgenology. Doctor Fenton has been a member of the Medical Practice Board since 1977 and also is a member of the American College of Radiology, American Board of Radiology, American Roentgen Ray Society and the Radiological Society of North America. Presently Doctor Fenton is one of the Michigan counselors/elect to the American College of Radiology. He is a former three-term Bay City councilman, and holds a mechanical engineering degree from the University of Michigan.

Henry A. Kallet, MD, Jackson, is a practicing pathologist and an associate professor of pathology at Michigan State University. Doctor Kallet is a member of the House of Delegates for the College of American Pathology. He is a pathologist consultant for Blue Cross Blue Shield of Michigan and the Department of Social Services, and a member of the state Task Force for the Licensing and Regulation of Physician's Assistants. Doctor Kallet also serves on the MSMS Medicaid Liaison Committee and is chairman of the MSMS Third Party Payors Committee.

Carol E. Pearson, MD, Oak Park, is certified by the American Board of Psychology, Neurology, and Child Psychology. She has a private practice and consulting firm in Detroit and Oak Park. Doctor Pearson is the first female alumna to be appointed to the Board of Control for Intercollegiate Athletics at the University of Michigan. She also is a member of the university's Black Leadership Committee which is researching the information retention of black students. She is an associate professor of psychiatry at Wayne State University School of Medicine, trustee of the Merrill-Palmer Institute, a commissioner for the International Year of the Child, and consultant for the Lafayette Clinic and the Lula Belle Stewart Center for Unwed Mothers.

Florence A. Pillote, MD, Marquette, a practicing pediatrician, is senior member of the board. Doctor Pillote has served as chief of pediatrics, and as a member of the executive board at Marquette General Hospital, and is currently director of newborn services there. She is a member of the American Academy of Pediatrics.

Addison E. Prince, MD, Detroit, is a full-time specialist in obstetrics and gynecology. A graduate of Wayne State University School of Medicine, Doctor Prince is assistant professor of obstetrics and gynecology at WSU. Doctor Prince is a



Breneman



Fennessey



Fenton



Kallet



Pearson



Pillote



Prince



Rotter



Weddon

continued on page 204

Disciplinary actions, Michigan Board of Medicine

The following actions of the Michigan Board of Medicine were taken following investigation and appropriate administrative action, are printed from official memoranda to MSMS and are not editorialized:

December 15, 1979 to date

Name & Address	Date & Action Taken	Violation
Chiau-Seng Hwang, MD 515 W. Main Manchester, MI 48158 License #031279	12-5-79 Reprimand effective 12-18-79	Failure to use reasonable care and discrimination in the administration of drugs. Failure to conform to minimal standards of acceptable and prevailing medical practice, whether or not actual injury to a patient is established.
Jerome J. Wisneski, MD 26 Sheldon, S.E. Grand Rapids, MI 49502 License #027855	12-19-79 1 year suspension from 5-3-79 to 5-3-80	Obtaining, possessing, or attempting to obtain or possess a controlled substance without lawful authority. Selling, prescribing, giving away or administering drugs for other than lawful diagnostic or therapeutic purposes.
William F. Blair, MD 10684 E. Outer Drive Detroit, MI 48224 License #019574	12-12-79 License issued	Licensee applied for controlled substance license and an order to show cause was issued

DOCTOR KUIPER/continued

"The Board's viewpoint," he explains, "is that the staff of the Department of Licensing and Regulation (L and R) has usurped some of the Board's investigative functions and at the same time has given Board members administrative responsibilities that should be handled by L and R staff," explains Doctor Kuiper.

"Being on a board is an honor," says Doctor Kuiper, "but it is a voluntary task (it pays only \$50 a day). I would like to see the paid staff do most of the leg work and let the decision-making be assigned to the Board."

Doctor Kuiper has asked the state attorney general's office to draft a detailed statement of the board's obligations and responsibilities and those of the L and R staff, as prescribed by the Public Health Code. He expects

that statement to end present strife and tension and allow the Board to get on with its work.

The Board of Medicine consists of nine physicians, three consumer representatives and a physician's assistant.

Doctor Kuiper, who is now in his second four-year term on the Board, has a private practice and also serves as vice president for medical affairs at St. Lawrence Hospital in Lansing. He is also chief of staff-elect and will become chief of staff in January 1981.

Originally of Grand Rapids, Doctor Kuiper holds a BS from Calvin College and an MD from Loyola Medical School. Before entering private practice, he was an instructor at the University of Michigan and an assistant professor of medicine at Michigan State University.

BOARD MEMBERS/continued

member of the American Colleges of Obstetrics and Gynecology and of Surgeons, and the Detroit Surgical Society. He also is a graduate of the University of Michigan's School of Public Health where he specialized in maternal and child care. Doctor Prince served on the commission for the Public Health Statute Revision Project and is a member of the National Association for the Advancement of Colored People.

Norman J. Rotter, MD, Detroit, graduated from Wayne State University School of Medicine and is a full-time specialist in neurological surgery. Doctor Rotter is secretary of the Southeast Michigan Surgical Society and is a member of the Congress of Neurological Surgeons, a Fellow of the American College of Surgeons, and a member of the Detroit Neurological Academy. Prior to his appointment to the Board of Medicine, Doctor Rotter served on the MSMS Medical Practice Board Liaison Committee and was a delegate to the Michigan Council of Specialty Societies. He also has served on the MSMS Public Relations Committee. Doctor Rotter instructed a Neurological Teaching Program for residents at Oakland Hospital for a two year period ending summer 1979, and has served as medical advisor for the Berkley School System's Junior Achievement Program.

Edward R. Weddon, MD, Stockbridge, current is an MSMS delegate. He also has served on various MSMS committees such as the Task Force on Committee Structure in 1977 and the Regional Peer Review Board in 1970. In addition to his private family practice, Doctor Weddon is a staff member of the W.A. Foote Memorial Hospital in Jackson. He is the past president of the Jackson Medical Society and is currently on its executive board. Doctor Weddon has served on the board of the Michigan Doctors' Political Action Committee, the Stockbridge Community Schools' Reproductive Education Committee and the Stockbridge Board of Education. Presently, Doctor Weddon is co-author of the **rural health** column in *Michigan Farmer* magazine.



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Sen. Corbin could be gubernatorial prospect

By Willah Weddon, special to Michigan Medicine



Sen. Corbin

Assistant Senate Majority Leader Gary G. Corbin has introduced the "Unprofessional Conduct" bill (SB 497). It is one of several areas in which this key legislator has an impact on medical practice in Michigan.

SB 497 would make it unprofessional for a licensed physician to promote for personal gain the use of an unnecessary drug, device or service or to require a patient to secure the same from a place of business in which the physician has a material financial interest. A companion bill (SB 498) sets the financial interest at more than five percent.

What Sen. Corbin actually is proposing is a softening of the Public Health Code which requires, according to the Michigan attorney general, there be absolutely no financial interest by physicians in hospitals or laboratories.

Under the Corbin bills, physicians could support bond drives for hospitals. Sen. Corbin feels this is vital, particularly in rural areas.

Enforcement of the provision in the Public Health Code has been held up by a court case in his home Genesee County, he points out.

Corbin's concerns

Corbin expects the economic pressure of a tight state budget this

year will reflect on medical school allocations.

Medicaid, too, is a concern to Corbin and he believes overview by the state must be very thorough to prevent abuses that castigate the entire program.

"What we want to do is enhance health care opportunities in Michigan and, at the same time, manage them in a way that their cost does not escalate enormously," he says.

Corbin meets frequently with members of the Genesee County Medical Society and feels the monthly meetings are "very valuable," in understanding not only the medical profession but the medical needs of the community.

"I think communication between legislators and the medical field has to be maintained and should be wide open," he says.

"There are times when the medical community and I have differences of opinion. But I enjoy working with physicians on community and state levels," he says. "I want to maintain an open-door policy."

"I feel strongly that the health needs of people in the nation be met," he replied in regard to a national health program. "I'm not sure yet which is the best vehicle to get there, but I think the medical profession should be highly involved in reaching that point."

Corbin's background

Although Corbin admits he's had disagreements with his fellow Democrat, Majority Leader William Faust, over some committee appointments, he agrees with him wholeheartedly in his reform measures. These add accountability of Senate funds and curb the abuse of power, he points out. He rates his own political philosophy as middle-of-the road to liberal.

"I generally have good support from the unions in the state," he says, pointing out that most of the people in his district are union members.

Corbin began adult life working the night shift in an automotive parts company. At the same time he obtained his BA and Master of Divinity from Anderson College in his native Indiana.

He came to Michigan in 1967 to begin a six-and-a-half year stint as minister of the Community Church of God in the Flint suburb of Clio. During the latter four years he served on the Genesee County Board of Commissioners, a full-time job in itself, he recalls.

When he decided to run for the Michigan Senate seat in his 25th district, Corbin resigned his ministry and began campaigning. From March, 1974, until the following November he knocked on 24,000 doors. He won the election.

"I think some of the motivations I had for entering the ministry are the same I had for entering public life," he says. "I felt there were opportunities to initiate changes and meet the needs of people in a dramatic fashion."

As a freshman senator he was picked to chair the Committee on Colleges and Universities (now merged with the Education Committee) and within two years was elected assistant majority leader, a post he still holds. This year he was named to head the Finance Committee which deals with taxation and revenue sources.

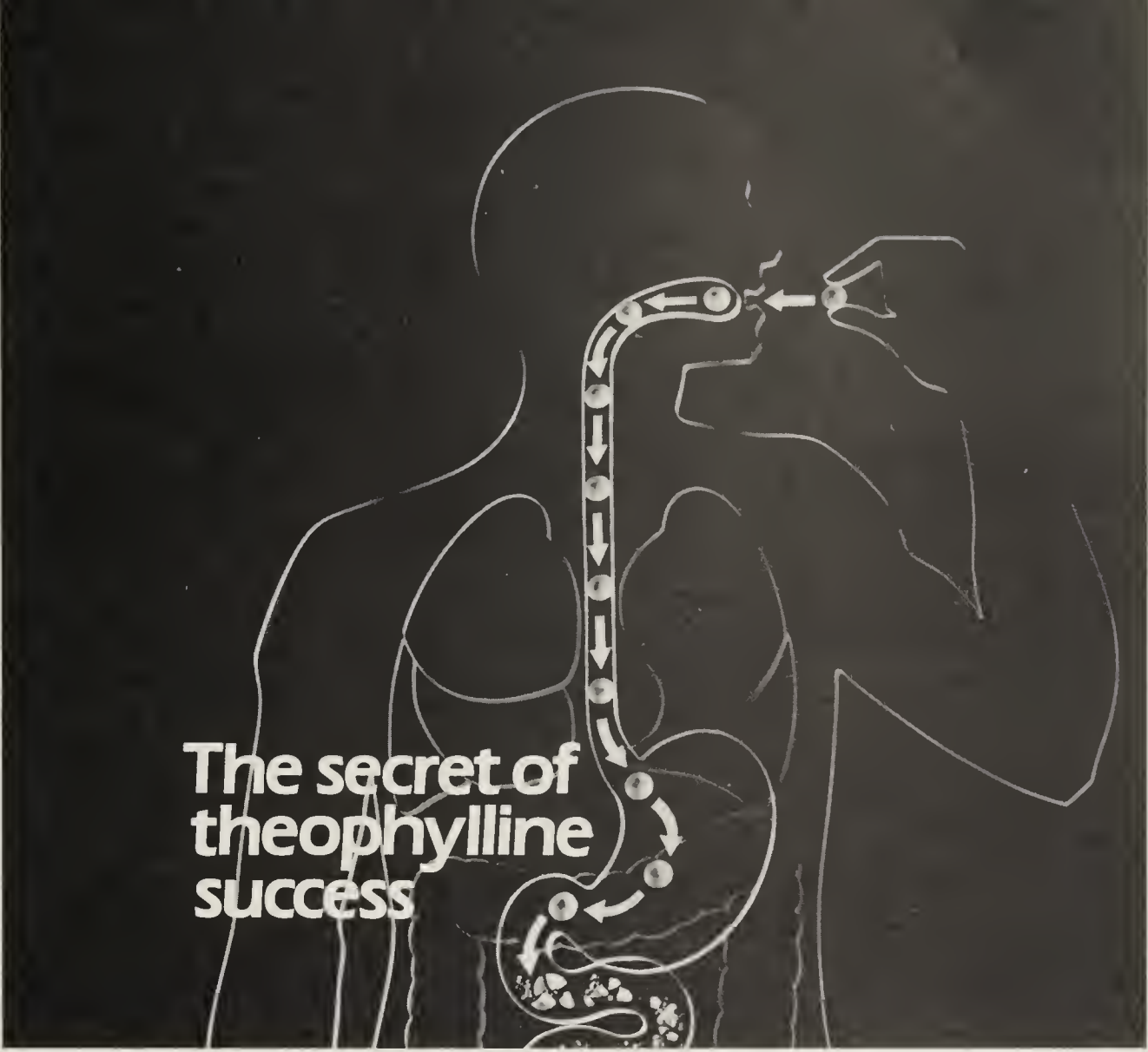
Corbin's future

What does the future hold for Senator Corbin? He acknowledges other people have encouraged him to pursue higher political office. He wants to do a good job in the State Senate so he can ask for their support if he so decides. The congressional races in his district are pretty well sewed up in the near future and he'd like to stay in Michigan.

This leaves the gubernatorial seat. There are many Democrats who are eyeing Corbin as a possible candidate.

Why such speculation? Corbin is packaged right. He's youthful, energetic, good-looking, confident but not over-confident, and able to field questions adroitly. The former minister might just be the answer to the Democrats' prayers.

One of a continuing series of Michigan Medicine profiles of key Michigan legislators.



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PRECAUTIONS. Concurrent use of other xanthine-containing preparations may lead to adverse reactions, particularly CNS stimulation in children

ADVERSE REACTIONS. Gastric distress and, occasionally, palpitation and CNS stimulation have been reported

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HEALTH PLANNING UPDATE

By Dennis Paradis, Director
MSMS Physician/HSA Support Center



Philosophy of hospital bed reduction

Walter McClure, PhD, of the Minnesota-based think-tank InterStudy is the author of much of the philosophical underpinnings of the drive to reduce excess hospital beds.

In the 1976 publication *Reducing Excess Hospital Capacity*, Doctor McClure suggests that the United States should adopt a policy to reduce hospital capacity by 10 percent as a cost containment strategy. While this message has been taken to heart by Michigan

Michigan Medicine high in national ad sales

Michigan Medicine closed 1979 with a high standing among its fellow state medical journals in number of national advertising pages.

Michigan Medicine had the third highest standing behind *The Journal of the Florida State Medical Association*, and *Texas Medicine*. On the average, Michigan Medicine had 23.8 pages of national advertising per month throughout 1979.

This means that the MSMS journal was the third most used state medical journal publication by the national advertisers, most of whom are drug companies.

These figures compare Michigan Medicine to the other journals represented by the State Medical Journal Advertising Bureau of Chicago, which has 33 member journals. In contrast, *The New England Journal of Medicine* and the *Journal of the American Medical Association* have 37.9 and 32.2 average monthly national advertising pages.

Among Michigan Medicine's most consistent national advertisers are Roche Products, Inc.; Merrell National Laboratories; Eli Lilly and Company; The Brown Pharmaceutical Co., Inc.; Burroughs Wellcome Co.; Sandoz Pharmaceutical; Merck, Sharp and Dohme; Smith, Kline and French; the Mead Johnson Company, and Upjohn Company.

legislators and health planners, several of Doctor McClure's other findings are not heeded.

On the issue of cost savings, Doctor McClure comments that the greatest cost savings are from the closure of entire hospitals (six to eight percent of per capita costs). The same savings can be obtained by placing a moratorium on hospital expansion until the population expands to fill the existing capacity, he says. Although the moratorium approach takes longer (depending on the population growth rate) it accomplishes the same savings without social disruption or the costly 'front-end' expenses of the closure approach.

On the identification of excess hospital capacity, several issues are raised.

Doctor McClure says that a focus on hospital beds is not adequate for cost containment purposes. "Planning goals must therefore be stated in terms of all four measures of capacity: beds, service facilities, labor and capital."

Although Doctor McClure does not feel demand is an adequate base for hospital need calculations, he also expresses concern over the determination of need through population data: "The present capability of health planners to perform population-based planning appears weak."

Doctor McClure's suggestion is that hospital bed need be based on demand-based projections that are modified downward. The greatest risk in any need determination methodology is that it does not identify hospitals with few unnecessary admissions. These hospitals, according to Doctor McClure "should be exempted from capacity reduction as a reward for their good performance."

Perhaps the most salient observation made by Doctor McClure relates to the true nature of a hospital bed reduction program: "At heart, excess hospital capacity reduction is just a socio-political problem, and only secondarily a technical problem. The most sophisticated technical methods in the world will not avail if the socio-political problem is not resolved."

Recently, in a publication entitled *Conservation and Other Policy Options to Reduce Excess Hospital Capacity*, Doctor McClure, et al., reached some more conclusions applicable to the Michigan situation. He stated that hospital closure and delicensure programs don't save money and should be kept to a minimum.

He contends that it will be difficult to eliminate hospitals on the basis of "necessity." Therefore, political considerations will focus on the smaller and politically weaker institutions. "They aren't likely to include the 12 percent of the hospitals that account for 50 percent of the expenditures, or even the 50 percent of the hospitals that account for 90 percent of the expenditures." The outcome of such an approach is predicted as, "a growing trail of angry communities and legislators who will make further progress more difficult."

The approach to hospital bed reduction suggested by Doctor McClure is a federal level strategy using a combination of regulatory tools and induced market forces. This approach will be developed in an upcoming report *Competitive Market and Regulatory Strategies for Medical Care*.

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Doctor Ochberg

Michigan's Doctor Ochberg advising standby hostage team

By Willah Weddon, Special to Michigan Medicine

A medical team has been organized and placed on standby since early February to care for American hostages as soon as they are released from the US Embassy in the Iranian capital, according to Frank M. Ochberg, MD, Director of Michigan's Department of Mental Health.

"Plans are made for a one-week decompression period for the hostages," he says. "The week is to be used for intensive medical examinations, psychological debriefing and to give the hostages time to begin to develop a sense of camaraderie."

"They probably haven't talked much among themselves," he says. "A colleagueship could serve them well when they return to everyday living with similar problems."

The hostages have become heroes in a sense, he points out. It is considered important, particularly in view of the length of time they have been confined, to assist the hostages in their immediate and future adjustments.

Ochberg called in

A group of marriage and family counselors met in February on Purdue University campus to pool resources, prepare papers for the State Department and establish a support network to be available throughout the country. The group includes experts on problems of prisoners of war, forensic psychiatrists and people knowledgeable about other forms of family disruptions in the wake of victimization.

Psychiatrist Ochberg was called in to speak to members as he is the nation's top expert on crisis management. His research has dealt with reactions of hostages during and after their confinement by terrorists. Although not a member of the Purdue group or the strategy groups, he recently has been a member of the National Security Council and a consultant to the Federal Bureau of Investigation's Terrorism Research and Management staff.

In his research on the hostage situation (the role of the victim, stress, coping and psychological effects), Doctor Ochberg has found between one-quarter to one-half of those released have problems in the early aftermath.

When hostages come out, feeling a certain amount of peace and security, they can be overwhelmed by nightmares, bloody fantasies or visions, he says. They can be easily startled, easily upset, develop phobias . . . and these can lead to some deleterious uses of self-medication. The bottled-up emotions can manifest themselves in physical problems which warrant serious medical attention for two years, he cautions.

"A depression occurs to some victims when the new-found celebrity status wears off and there is a realization of the humiliation and degradation of having been treated as something less than a human being," he continued. "This can cause sexual dysfunction and has led to some problems with intimate relationships

than can be identified and worked through."

Ochberg's research vital

Doctor Ochberg's research will play a vital role in helping the Iranian hostages return to a normal life. Not only will it provide background during the first week of observation to identify present or potential problems, but also will help those dealing with problems arising later in the home community.

Bishop Tom Gumbleton of the Archdiocese in Detroit, who was on the Christmas day mission to the hostages in Iran, is said to have an excellent relationship with 30 of the 50 families involved. The two have conferred and Doctor Ochberg has agreed to assist him if he finds families have problems once they are resettled.

The Michigan Psychiatric Association and members of the MDMH also will be available to provide help for returning hostages or their families, if they should request it.

Some of the hostages probably had some training in how to cope with a situation such as they have been confronted with and this may help, says Doctor Ochberg.

Basically, however, Doctor Ochberg feels some people have an innate ability to cope better than others. He also hopes the hostages will not be ashamed to ask for help, as assistance will be available and waiting.

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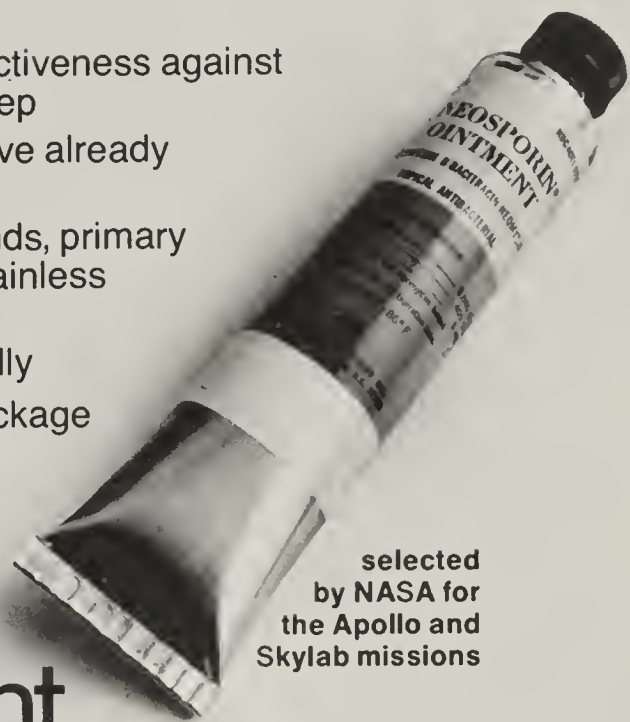
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PRECAUTIONS: As with other antibacterial preparations,

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ADVERSE REACTIONS: Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of persons allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section).

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INDICATION: For relief of constipation.

PATIENT WARNING: Should not be used in the presence of undiagnosed abdominal pain. Frequent or prolonged use without the direction of a physician is not recommended. Such use may lead to laxative dependence.

DIRECTIONS FOR USE—ADULTS: Before breakfast and after the evening meal, one to two rounded teaspoonfuls of Perdiem™ granules should be placed in the mouth and swallowed with a full glass of warm or cold beverage. Perdiem™ granules should not be chewed. After Perdiem™ takes effect (usually after 24 hours, but possibly not before 36-48 hours), reduce the morning and evening doses to one rounded teaspoonful. Subsequent doses should be adjusted after adequate laxation is obtained.

IN OBSTINATE CASES: Perdiem™ may be taken more frequently, up to two rounded teaspoonfuls every six hours.

FOR PATIENTS HABITUATED TO STRONG PURGATIVES: Two rounded teaspoonfuls of Perdiem™ in the morning and evening may be required along with half the usual dose of the purgative being used. The purgative should be discontinued as soon as possible and the dosage of Perdiem™ granules reduced when and if bowel tone shows lessened laxative dependence.

FOR COLOSTOMY PATIENTS: To ensure formed stools, give one to two rounded teaspoonfuls of Perdiem™ in the evening with warm liquid.

DURING PREGNANCY: Give one to two rounded teaspoonfuls each evening.

FOR CLINICAL REGULATION: For patients confined to bed, for those of inactive habits, and in the presence of cardiovascular disease where straining must be avoided, one rounded teaspoonful of Perdiem™ taken once or twice daily will provide regular bowel habits. Take with a full glass of water or beverage.

FOR CHILDREN: From age 7—11 years, give one rounded teaspoonful one to two times daily. From age 12 and older, give adult dosage.

NOTE: It is extremely important that Perdiem™ should be taken with a plentiful supply of liquid.

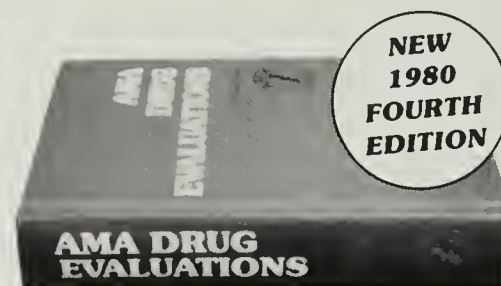
HOW SUPPLIED: Granules: 100 gram (3.5 oz) and 250 gram (8.8 oz) canisters.



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Doctor Stack dropping out of public life, into private emphasis on infant mental health

By Martha Smith, Special to Michigan Medicine

An enlightening new look into infant mental health is in the plans of Alma physician Jack Stack, MD and his staff. Local townspeople stand to benefit.

Doctor Stack, a recognized figure in Michigan politics and a newly board-certified psychiatrist, is the impetus for the development of a new infant mental health clinic in Alma.

The clinic, a 100-year-old remodeled building in the residential area of Alma, once served as a hospital. The richness and warmth of this older building complement the ideas and feelings of the staff and their plans.

With the help of researching university students and colleagues, Doctor Stack hopes to better understand a child's way of thinking. Emphasis here is on the interaction between the child and the mother, father, and "significant others." The effects of these interrelationships on the child's mental health are the basis for study.

As publisher of *The Infant Mental Health Journal*, Doctor Stack offers his readers information from distinguished practitioners and scholars on the combined influences of environment, family, cultural milieu, and heredity on an infant's mental health. Through this publication; his work in Alma; his memberships and active voice in local, state, national, and international mental health organizations, Doctor Stack has become recognized as a leader in the practice and promotion of mental health.

MSU board

This clinic, however, is only one area of interest for Doctor Stack. As a member of the Board of Trustees at Michigan State University, he also is active in affairs outside the medical profession.

Doctor Stack has faithfully served this board for seven years, and



Doctor Stack's converting a residential mansion to a new mental health clinic in Alma.

says, "All those who have attended college — and especially physicians — have been trained at the cost of the public. All of us as physicians have a responsibility to serve them."

In the seven years Doctor Stack has presided on this board he has made several major contributions. He presented a resolution for an admission policy to insure that students wishing to attend Michigan State University's Colleges of Human and Osteopathic Medicine are considered on the basis of their personal accomplishments, gradepoint, and integrity, not on the basis of who they know with personal or political pull.

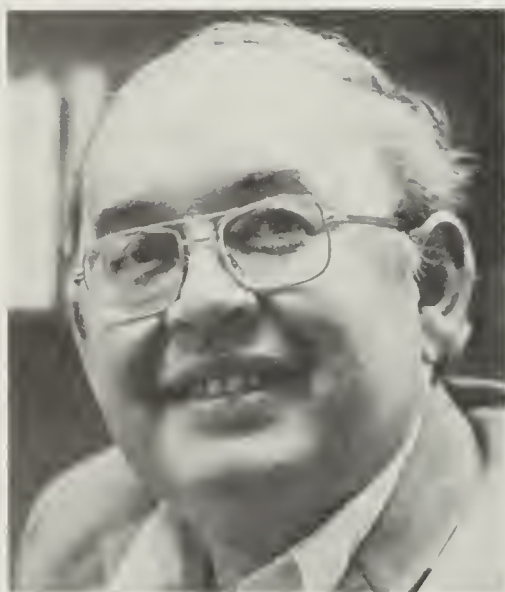
This resolution was unanimously accepted by all board members and included in the admissions policy. The action takes pressure off those individuals who are asked to vouch for a student's acceptance as well as benefits the student who has no personal or political pull. Doctor Stack believes that trustees should only intervene in the admissions process if a student is not getting a "fair shake."

As chairman of the MSU board's Health Committee, Doctor Stack was influential in establishing prevention and treatment programs for sexual assaults and sexual harassment on the campus. He also helped to acknowledge Michigan State's nursing school as an equal and vital part of health care. Doctor Stack suggested entitling the School of Nursing the College of Nursing, and to appoint a dean with equal status to that of other deans in the medical colleges. Doctor Stack also established the position of Vice President of Health Services in order to allow the medical school executive representation in the University.

Family practice

One of the most outstanding contributions Doctor Stack is given credit for is influencing the board of trustees to establish Michigan's first Department of Family Practice in the MSU College of Human Medicine.

As a member of the Michigan Academy of Family Practice's legislative committee in 1971, Doctor Stack



Doctor Stack

was active in presenting this resolution to the Michigan legislature. The legislature acknowledged the importance of establishing a Department of Family Practice in Michigan Universities to improve medical training in this area, to stimulate interest, and to offer a role model for those students interested in pursuing a career in family practice.

Although the College of Osteopathic Medicine already had established such a department, Doctor Stack impressed upon the board the importance of each college keeping its professional identity separate.

Doctor Stack is active on the University's board because he is interested in serving the community and improving the higher education. He claims, "There is much satisfaction and reward in knowing others have benefited from your service."

Although Doctor Stack has chosen not to run for re-election later this year, he encourages others to investigate the possibility of serving in public positions. Now with his debt repaid to his alma mater, other issues and institutions will receive this man's dedication and resourcefulness.

Sex education

As a member of the Michigan Reproductive Health Rights Council, Doctor Stack is active in implementing sex education in the school system. His political involvement

proved an impetus in passing the Fox Bill, which allowed sex education to be taught in Michigan schools.

According to Doctor Stack, "Sex education is not a class in human plumbing. Emphasis should be placed on the relationships young people encounter and their feelings about those relationships and about themselves. One's self-esteem and perception of what it means to be sexually active should be the objective of such a course."

He says further, "Young people in touch with their emotions and aware of the responsibility that accompanies being sexually active, will be the key to reducing social disease, abortion, and adolescent pregnancy, as well as the social and emotional consequences of these experiences."

Doctor Stack feels it is physicians' responsibility to deal with these problems when they arise and therefore it should be physicians' concern what laws have mandates for medical practice and the treatment of those seeking help.

"There is need for doctors' political involvement to help influence decisions on health laws and regulations," Doctor Stack says. "These decisions help determine a doctor's practice and what he/she can and cannot do for patients."

Doctor Stack also acknowledges his professional colleagues as opinion leaders who should use their positions to influence others. By being involved on school boards, and in other community groups, doctors are able to integrate themselves into the ruling bodies of their communities.

Doctor Stack sees politics as, "the art of governing one's own community." The ethical politician who has the public's best interest in mind should be recognized and supported, he says. "Such candidates need financial support as well as active participation to put them in a position to help the medical profession and their community." He urges physicians to make an effort to understand the selection and election process of candidates in their areas as well as on the state level.

Physicians' involvement

Doctor Stack is a living example of how doctors' political involvement can improve the medical environment. He and other physicians in-

itiated legislation which now allows in-patient treatment of mental health patients in general hospitals.

This in-patient policy has encouraged mental health facilities at the community level and reserves the state institution as a sophisticated back-up facility. The financial feasibility of this arrangement is recognized by both the patient and the taxpayer who support this state institution.

As a result of this ruling, Michigan has the fewest number of admissions at the state level. Also, treatment of patients is administered in familiar and friendly surroundings which can facilitate their recovery period.

When Doctor Stack graduated from med school in 1963, he felt a personal and professional responsibility to be politically involved. He has fulfilled this responsibility through a diverse range of activities. He has served as the director of the National Board of Zero Population Growth, the National Association for the Repeal of Abortion Laws, and as chairman of the Michigan Coordinating Committee for Abortion Reform.

Doctor Stack plans a visit to Portugal this year to speak at a convention sponsored by the International Association for Mental Health. He also will be serving as finance chairman for Dick Allen, a candidate for congress in the 10th District.

A family practitioner with a soft but commanding voice, he has contributed much to his profession, to his community and to his fellow human beings.

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A variety of key MSMS activities are coordinated through the office of MSMS Director Warren F. Tryloff.

These activities include personnel supervision and administrative coordination, communications with the public and with members, coordinating of all MSMS committee arrangements, and CME programming efforts.

MSMS director since 1969, Mr. Tryloff sees that all staff support activities run smoothly and at the direction of the 9,500 MSMS members, their elected representatives, councilors and officers. He oversees a staff of 42 persons headquartered in East Lansing in the original MSMS build-

ing and adjoining new Cyrus Stockwell Building.

In the office of the director are the following:

Donna J. Baetz, secretary for communications efforts, primarily with the public. Mrs. Baetz assists with registration of major MSMS meetings, in addition to her secretarial duties.

Jill A. Barnum, secretary for personnel, administrative and CME programming efforts. Miss Barnum provides key assistance work throughout the year in the presentation of the MSMS Annual Scientific Meeting.

Mary K. "Katie" Brewbaker is coordinator of MSMS committees, maintaining committee membership

files, correspondence and minutes, and making arrangements for meetings in the MSMS headquarters building. She also staffs the MSMS Maternal Health Committee and its major annual meeting, the Maternal Health Conference.

Vada L. Davis is chief of the MSMS Bureau of Administration, and thus oversees all staff personnel activities. Mrs. Davis staffs MSMS Council meetings, and also the MSMS Judicial Commission.

Sherry L. Fent is MSMS coordinator of CME Programming. She staffs the MSMS Task Force on the Annual Scientific Meeting and heads staff management of the annual, three-day MSMS CME event itself. She also oversees the organization of the annual Maternal Health and Sports Medicine conferences, to insure their Category I CME standing.

Bonnie L. Groff is secretary for MSMS communications efforts, primarily with members. She serves in a support role for production of *Michigan Medicine* and *Medigram*, including editorial, advertising and circulation activities.

William E. Madigan is assistant to the director. His responsibilities include the coordination of MSMS

MSMS headquarters is readily accessible by telephone to every member.

But how many members have had the chance to visit the beautiful MSMS buildings in East Lansing and speak in person with those people behind the phone voices? Probably a majority of members have never had that chance.

Thus, *Michigan Medicine* continues with this issue to print photos of the MSMS headquarters staff along with their names and professional titles. Staff members will be grouped by departments.

This issue will feature the Department of Operations and Member Services. The Department of Economics and Finance began the series in the November issue, and Government Relations followed in December.

Other departments will be featured in future issues.

legal and professional liability activities, including liaison with the Michigan Insurance Bureau and Malpractice Insurance Companies. He also staffs the MSMS arbitration committee, serves as liaison with specialty societies and other allied health organizations.

Judith E. Marr is editor of *Michigan Medicine* and *Medigram*, the official MSMS publications. She also assists in production of the Digest of Proceedings of the MSMS House of Delegates, the constitution and by-laws and Roster of Members, and staffs the MSMS Committee on Publications.

Merwyn G. "Mert" Scholten is chief of the MSMS Office of Communications. He is responsible for all relationships with news media, news conferences and news releases. He

assists physicians across the state in producing television, radio and newspaper informational programs, and shares with Wayne Burmeister membership recruitment and retention efforts. He staffs several key committees, including those on public service, membership, impaired physicians and sports medicine.

Nancy VanderBeek is executive secretary to Mr. Tryloff. In addition to her regular secretarial duties, she maintains files for all correspondence, legal opinions and other pertinent information received by the director's office.

Nancy Wimmer is Mr. Madigan's secretary. As well as taking care of the general office responsibilities, she handles the distribution of arbitration agreement forms and booklets requested and works on special projects.

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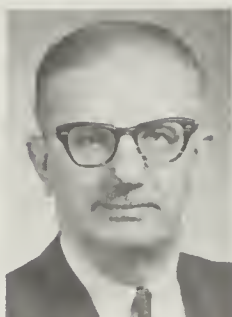
By Katie Brewbaker, MSMS staff



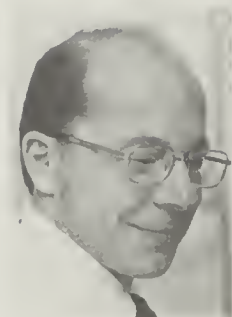
Doctor Loree



Doctor O'Dell



Doctor Payne



Doctor Sander



Doctor Stryker



Doctor Zako

The reputation of **Charles Sander, MD**, goes beyond his work as assistant chairman of MSU's Department of Pathology. He is also known as an accomplished violinist and gave his 12th annual recital at the University Music Building auditorium in March. ... Flint welcomes the return of **Lewis E. Simoni, MD**, as vice-president of Medical Affairs at St. Joseph Hospital. Doctor Simoni spent a term as professor and chairman of the Department of Family Practice at East Tennessee State University. ... **Joan Stryker, MD**, of the Hutzel Hospital Pregnant Drug Addict Clinic in Detroit, recently testified before a congressional committee on the adverse effects suffered by children born of drug-addicted mothers. ... Named an Ambassador for Epilepsy during the 11th International Symposium on Epilepsy in Florence, Italy, is **Ernest A. Rodin, MD**, Detroit, in recognition of his special contributions to the international epilepsy movement. ... After serving over 40 years, **Noel Hershey, MD**, has retired from his medical practice in Niles. His patients expressed their appreciation for his dedication at a party held in his honor. ... **Louis R. Zako, MD**, chairman of the MSMS Council, has been appointed to the AMA Council on Legislation. ... **James A. Greene, III, MD**, Kalamazoo, is new chairman of the planning committee of the End Stage Renal Disease Network Coordinating Council. ... Newly elected chairman of the Flex Board of The Federation of State Medical Boards of the United States is **C. Allen Payne, MD**, Grand Rapids. ... **Frederick C. O'Dell, Jr., MD**, is governor-at-large

from Michigan to the American College of Surgeons Board of Governors. ... **James T. Harrison, MD**, who has served as public health director for eight counties in Northern Michigan, assumed the post of medical coordinator for the Office of Local Health Services for the Michigan Department of Public Health effective Feb. 4. ... **John A. Rupke, MD**, Grand Rapids, has been re-elected chairman of the AMA Commission on Emergency Medical Services. ... Recipient of the 1979 Distinguished Service Award of the National Kidney Foundation is **Franklin D. McDonald, MD**, professor of medicine and director of the nephrology division at WSU School of Medicine. Doctor McDonald was recognized for his contributions as a volunteer of the foundation and, particularly, for his service as representative to the American Blood Commission. ... **Doctor Bruce Feldstein**, Southfield, has recently returned from a three-month voluntary tour of duty at a refugee camp in Cambodia. ... During his 90 years, **Doctor Maurice C. Loree**, of Lansing, has seen much of life and witnessed mind-boggling changes in medicine. The colorful Doctor Loree and his bride for the past 60 years were the subjects of a recent feature article in the *Lansing State Journal*. ... Henry Ford Hospital has announced the election of **Richard D. Nichols, MD**, as chairman of the Council of Henry Ford Hospital, the governing body of the Hospital's medical and surgical staff. Ford also welcomes to its staff **D. Paul Horan, MD**, as head of the HFH Division of Trauma and Emergency Surgery. ... Recent appointments made by the

University of Michigan Hospital are **Robert C. Kelsch, MD**, director of the section of general pediatrics, **Geoffrey Lane, MD**, chief of pediatric anesthesiology, and **Dietrich W. Roloff, MD**, director of Newborn Services. ... **Patricia Lynne-Davies, MD**, has accepted appointment as chief of pulmonary medicine at Harper-Grace Hospitals and professor of the department of internal medicine at WSU School of Medicine.

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MEETINGS



MSMS, MSMS/A, AMA and medical assistants

April 17 — AMA 33rd National Conference on Rural Health, Sheraton-Boston, contact: Barbara Chapman, 312/751-6604 or Gary Schwartz, 312/751-6431.

April 17-19 — Annual Convention and House of Delegates, State of Michigan Branch, American Association of Medical Assistants, Hilton Inn at Plymouth, contact: Margaret Broadwell, 16686 East Eight Mile Rd., Detroit, 48205.

April 21 — MSMS Auxiliary Legislative Day, Kellogg Center, East Lansing, contact: Caroline Rich, MSMS headquarters.

April 24-26 — AMA 76th Congress on Medical Education, Palmer House, Chicago, contact: John Fauser, MD, AMA, 535 N. Dearborn St., Chicago, IL 60610.

April 25-27 — 1980 MSMS House of Delegates, Michigan Inn, Southfield, contact: Richard Campau, MSMS headquarters.

May 5-7 — MSMS Auxiliary 54th Annual Convention, Weber Inn, Ann Arbor, contact: Caroline Rich, MSMS headquarters.

June 13-14 — AMA "New Directions for Medical Care — A Challenge of the 80's," Boston, contact: AMA, Dept. of Hospitals and Health Facilities, 535 N. Dearborn St., Chicago, IL 60610.

July 10-13 — MSMS Council, Holiday Inn, Marquette, contact: Warren Tryloff, MSMS headquarters.

Sept. 10 — MSMS Council, MSMS headquarters, contact: Warren Tryloff, MSMS headquarters.

Oct. 22 — MSMS Council, MSMS headquarters, contact: Warren Tryloff, MSMS headquarters.

Nov. 18-19-20 — 1980 MSMS Annual Scientific Meeting, Hyatt Regency Dearborn, contact: Sherry L. Fent, MSMS headquarters.

Dec. 3 — MSMS Council, MSMS headquarters, contact: Warren Tryloff, MSMS headquarters.

Other meetings

April 26-27, May 17-18 — Sexuality Training for Professionals, at Michigan League, Ann Arbor, contact: Michael Brown, 6869 Marshall Rd., Dexter, 48130.

May 1-2 — Annual Meeting and Resident Surgeons Day, Michigan Chapter, American College of Surgeons, at Detroit, contact: J. H. McLaughlin, MD, 604 N. Woodward, Birmingham, 48011.

May 1-2 — Department of Mental Health Spring Conference, Holiday Inn, Traverse City, contact: Eric Goldstein, Pharm.D., Michigan Department of Mental Health, Office of Health Services, 6th Floor, Lewis Cass Building, Lansing, MI 48962.

May 2 — Annual Meeting, Michigan Society of Thoracic Surgeons, at Detroit, contact: Rodman E. Taber, MD, Michigan Society of Thoracic Surgeons, 30050 Hoover Rd., Warren, 48093.

May 7 — Executive Committee Meeting, Michigan Allergy Society, at Henry Ford Hospital, Detroit, contact: Benjamin Stone, MD, 1005 Abbott Rd., East Lansing, 48823.

May 17-18 — Oakland County Medical Society and AMA's Department of Negotiations Seminar on Negotiations, Michigan Inn, Southfield, contact: John B. Bryan, MD, 313/288-6240.

May 21-23 — Michigan Hospital Association Medical Staff/Trustee/Administrator Forum, Boyne Mountain Lodge, contact: Michigan Hospital Association, 2213 E. Grand River Ave., Lansing, 48912.

May 28-30 — Seventh Annual Michigan Emergency Medicine Assembly, Michigan Chapter, American College of Emergency Physicians, Grand Hotel, Mackinac Island, contact: Susan Aldrich, Michigan Chapter ACEP, 1305 Abbott Rd., Suite 102, P.O. Box 1611, East Lansing, 48823.

May 29-31 — 1980 American Hospital Association National Conference on Trustees, Renaissance Center, Detroit, contact: American Hospital Association, 840 N. Lakeshore Dr., Chicago, IL 60611.

June 13-15 — Annual Meeting Michigan Dermatological Society, Bay Valley Inn, Bay City, contact: Alejandro Morales, MD, Dept. of Dermatology, Henry Ford Hospital, 2799 W. Grand Blvd., Detroit, 48202.

June 13-15 — Annual Meeting, Michigan Chapter, American College of Chest Physicians, at Boyne Highlands, Boyne City, contact: Susan Gibson, American Lung Association of Southeast Michigan, 28 W. Adams, Detroit, 48226, 313/961-1697.

June 26-27 — Michigan Hospital Association Annual Meeting, Grand Hotel, Mackinac Island, contact: Michigan Hospital Association, 2213 E. Grand River Ave., Lansing, 48912.

June 8-10 — Annual Scientific Meeting, Michigan Chapter, American Academy of Pediatrics, Bay Valley Inn, Bay City, contact: Miles Tiernan, 32245 Hearthstone, Farmington Hills, 48018, 313/553-3646.

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CATEGORY I COURSES

Michigan Medicine each month carries a list of opportunities in Michigan for doctors of medicine to obtain Category I credit toward meeting the requirements of Michigan law. Sponsors of Category I programs and courses in Michigan are invited to submit information for the monthly calendar.

Each listing below, of programs that carry at least 3 hours of Category I credit, indicates a contact person, so the physician can obtain details. Physicians with questions about accredited programs may phone MSMS Headquarters, 517/337-1351.

The following have been accredited directly by the AMA or by MSMS CME Accrediting Committee. Physicians may wish to write to the hospitals and organizations that are accredited and ask to be placed on mailing lists for announcements about future programs.

Organizations:

American Association for Hand Surgery, Warren
American College of Emergency Physicians, Lansing
American College of Psychiatrists, Southfield
American Society of Colon and Rectal Surgeons, Detroit
American Society of Dermatopathology, Ann Arbor
Ann Arbor Psychiatric Association
Commission Professional and Hospital Activities, Ann Arbor
Michigan Academy of Family Physicians
Michigan Academy of Plastic Surgery
Michigan State Medical Society
Michigan State University College of Human Medicine, East Lansing
Michigan Chapter, American Academy of Pediatrics
Michigan Dermatological Society
Michigan Heart Association
Michigan Lung Association, Lansing
Michigan Ophthalmological Society
Michigan Psychoanalytic Society
Michigan Society of Anesthesiologists
Noah Worcester Dermatological Society, Detroit
Section of Gastroenterology, American Society for Gastroenterology, Detroit
University of Michigan Medical Center, Ann Arbor
University of Michigan School of Public Health
Wayne State University School of Medicine, Detroit

Hospitals:

Bay County Medical Education (Bay Medical Center, Bay Osteopathic Hospital, Bay City Samaritan Hospital)
William Beaumont Hospital, Royal Oak
Beyer Memorial Hospital, Ypsilanti
Blodgett Memorial Hospital, Grand Rapids
Bon Secours Hospital, Grosse Pointe
Burns Clinic Med. Center, PC/Northern Michigan Hospitals Inc., Petoskey
Butterworth Hospital, Grand Rapids
Central Michigan Community Hospital, Mt. Pleasant
Chippewa County War Memorial Hospital, Sault Ste. Marie

Community Health Center of Branch County, Coldwater
Community Hospital Association of Battle Creek
Cottage Hospital of Grosse Pointe
Detroit-Macomb Hospital Association
Dickinson County Memorial Hospital, Iron Mountain
Ferguson-Droste-Ferguson Hospital, Grand Rapids
Grace Hospital, Detroit
Gratiot Community Hospitals, Alma
Hawthorn Center, Northville
Henry Ford Hospital, Detroit
Heritage Hospital, Taylor
Holy Cross Hospital, Detroit
Hurley Medical Center, Flint
Ingham Medical Center, Lansing
Kalamazoo Regional Psychiatric Hospital
Lakeshore Continuing Medical Education, Inc. (Hackley Hospital and Mercy Hospital, Muskegon)
Leila Y. Post Montgomery Hospital, Battle Creek
Marquette General Hospital
McLaren General Hospital, Flint
Mecosta County General Hospital, Big Rapids
Mercy Hospital, Port Huron
Metropolitan Regional Psychiatric Hospital
Michigan Psychoanalytic Society, Southfield
Midland Hospital Center
Mt. Carmel Mercy Hospital & Med. Center, Detroit
Munson Medical Center, Traverse City
North Detroit General Hospital, Detroit
Northville Regional Psychiatric Hospital
Oakwood Hospital, Dearborn
Orthopedic Guild, Inc., St. Joseph
Pennock Hospital, Hastings
Pontiac General Hospital, Pontiac
Portage View Hospital, Hancock
Port Huron Hospital CME Committee
Providence Hospital, Saginaw
Saginaw Cooperative Hospitals, Inc., Saginaw
Southwestern Michigan Area Health Education Center (Bronson Hospital and Borgess Hospital), Kalamazoo
St. Francis Hospital, Escanaba
St. John Hospital, Detroit
St. Joseph Hospital, Flint
St. Joseph Mercy Hospital, Pontiac
St. Joseph Mercy Hospital, Ann Arbor
St. Lawrence Hospital, Lansing
St. Mary's Hospital, Grand Rapids
St. Mary Hospital, Livonia
Sinai Hospital of Detroit, Detroit
Southwest Detroit Hospital
Edward Sparrow Hospital, Lansing
Traverse City Regional Psychiatric Hospital, Traverse City
V.A. Hospital, Battle Creek
West Shore Consortium, CME, Ludington/Hart/Manistee
Ypsilanti Regional Psychiatric Hospital, Ypsilanti

Date: April 14-18, **Family Practice Review.** **Location:** Towsley Center, Ann Arbor. **Sponsor:** U-M Office of Continuing Medical Education. **For:** All interested physicians. **Cost:** \$275. **Contact:** Towsley Center for CME, 313/764-2287. **Approved for:** 33 hours of Category I Credit.

Date: April 18, **Fifth Annual Cardiac Rehabilitation Symposium.** **Location:** Borgess Medical Center Auditorium, Kalamazoo. **Sponsor:** Borgess Medical Center, Cardiac Rehabilitation Center. **Co-Sponsor:** Michigan Heart Association and American Academy of Family Physicians. **For:** All interested physicians, nurses and physical educators concerned with Cardiac Rehabilitation. **Cost:** \$50. **Contact:** E. Enrique Leguizamon, MD, Medical Director, CRI, Borgess Medical Center, 1521 Gull Rd., Kalamazoo 49001 616/383-8340. **Approved for:** 7 hours of Category I Credit.

Date: April 19, **Violence In The Family.** **Location:** Education and Research Center, Henry Ford Hospital, Detroit. **Sponsor:** Henry Ford Hospital. **For:** All interested physicians. **Cost:** \$70. **Contact:** Medical Education, Henry Ford Hospital, 2799 W. Grand Blvd., Detroit 48202 313/876-1464. **Approved for:** 7 hours of Category I Credit.

Date: April 21-25, **American Occupational Health Conference.** **Location:** Detroit Plaza and Cobo Hall, Detroit. **Sponsor:** American Occupational Medical Association. **For:** All interested medical personnel. **Contact:** American Occupational Medical Association, 150 N. Wacker Dr., Chicago, IL 60606. **Approved for:** 16½ hours of Category I Credit.

Date: April 23, **Common Dermatological Diseases.** **Location:** Sheraton Inn, Kalamazoo. **Sponsor:** Southwestern Michigan Area Health Education Center. **For:** All interested physicians. **Cost:** \$50. **Contact:** Charles L. Zeller, Jr., MD, 252 East Lovell, Kalamazoo 49007 (616) 383-6360. **Approved for:** 8 hours of Category I Credit.

Date: April 23-25, **Hematology Review.** **Location:** Towsley Center, Ann Arbor. **Sponsor:** U-M Office of Continuing Medical Education. **For:** Hematologists, Medical Technologists. **Cost:** \$190. **Contact:** Towsley Center for CME, 313/764-2287. **Approved for:** 24 hours of Category I Credit.

Date: April 24-26, **Ninth Annual Critical Care Symposium.** **Location:** Wayne County Medical Society Headquarters, 1010 Antietam, Detroit. **Co-Sponsors:** Michigan Committee on Trauma, A.C.S. and Department of Surgery, Wayne State University. **Cost:** \$100. **Contact:** Theresa Sokol, Dept. of Surgery, Wayne State Univ., 540 E. Canfield, Detroit, 48201. **Approved for:** 15 hours of Category I Credit.

Date: April 28-30, **Ob-Gyn Conference.** **Location:** Towsley Center, Ann Arbor. **Sponsor:** U-M Office of Continuing Medical Education. **For:** All interested physicians. **Cost:** \$175. **Contact:** Towsley Center for CME, 313/764-2287. **Approved for:** 21 hours of Category I Credit.

Date: April 30, **Pneumoniae: Cough-In '80!** **Location:** E.W. Sparrow Hospital, Lansing. **Sponsor:** E.W. Sparrow Hospital Department of Family Practice. **For:** All interested physicians. **Cost:** None. **Contact:** Jean Machtel, CME Coordinator, (517) 487-2790. **Approved for:** 4 hours of Category I Credit.

Date: April 30, **Pulmonary Medicine Update.** **Location:** Hurley Medical Center, Merliss Brown Auditorium. **Sponsor:** Hurley Medical Center. **For:** All interested physicians. **Contact:** Richard D. Garlick, Hurley Medical Center, Sixth Ave. and Begole, Flint 48502 313/766-0142. **Approved for:** 6 hours of Category I Credit.

Date: April 30, **Hypertension: Evaluation and Treatment.** **Location:** Towsley Center, Ann Ar-

bor. **Sponsor:** U-M Office of Continuing Medical Education. **For:** All interested physicians. **Cost:** \$65. **Contact:** Towsley Center for CME, 313/764-2287. **Approved for:** 7 hours of Category I Credit.

Date: May 1-3, **Medicolegal Investigation of Death.** **Location:** Plaza Hotel, Renaissance Center, Detroit. **Sponsor:** Michigan Medical-Legal Research and Educational Association, Wayne County Medical Examiner's Office and Wayne State University School of Medicine. **For:** Emergency room physicians, medical examiners, coroners and pathologists involved in medico-legal work. **Cost:** \$150. **Contact:** Elaine M. Sacra, Office of Medical Examiner of Wayne County, 400 East Lafayette, Detroit 48226. **Approved for:** 15½ hours of Category I Credit.

Date: May 2-3, 1980, **Nuclear Radiology Workshop.** **Location:** Towsley Center, Ann Arbor. **Sponsor:** U-M Office of Continuing Medical Education. **For:** All interested physicians. **Cost:** \$150. **Contact:** Floyd C. Pennington, Director, Office of Continuing Medical Education, Towsley Center, University of Michigan Medical School, Ann Arbor 48109. **Approved for:** 16 hours of Category I Credit.

Date: May 7-9, **23rd Annual Clinic Days.** **Location:** Detroit Medical Center. **Sponsor:** Children's Hospital of Michigan and Wayne State University School of Medicine. **For:** All interested physicians. **Contact:** Mary Rose Urban, Activities Coordinator, 313/494-5455. **Approved for:** 15 hours of Category I Credit.

Date: May 8-9, **Ophthalmology Conference.** **Location:** Towsley Center, University of Michigan. **Sponsor:** U-M Office of Continuing Medical Education. **For:** Ophthalmologists. **Cost:** \$160. **Contact:** Towsley Center for CME, 313/764-2287. **Approved for:** 16 hours of Category I Credit.

Date: May 9, **Oto Clinical Conference.** **Location:** Towsley Center, University of Michigan. **Sponsor:** U-M Office of Continuing Medical Education. **For:** All interested physicians. **Cost:** \$25. **Contact:** Towsley Center for CME, 313/764-2287. **Approved for:** 5½ hours of Category I Credit.

Date: May 10, **Pulmonary Pathology and Transbronchial Biopsy.** **Location:** Borgess Hospital, Kalamazoo. **Sponsor:** Michigan Society of Pathologists. **For:** Pathologists. **Contact:** T. A. Reyman, MD, Department of Pathology, Mt. Carmel Mercy Hospital, 6071 W. Outer Dr., Detroit 48202. **Approved for:** 3 hours of Category I Credit.

Date: May 12-14, **Current Perspectives in Ophthalmology: Spring Conference.** **Location:** Towsley Center, Ann Arbor. **Sponsor:** U-M Office of Continuing Medical Education. **For:** Ophthalmologists. **Cost:** \$175. **Contact:** Towsley Center for CME, 313/764-2287. **Approved for:** 17 hours of Category I Credit.

Date: May 12-16, **Head and Neck Oncology.** **Location:** Towsley Center, University of Michigan. **Sponsor:** U-M Office of Continuing Medical Education. **For:** All interested physicians. **Cost:** \$500. **Contact:** Towsley Center for CME, 313/764-2287. **Approved for:** 42½ hours of Category I Credit.

Date: May 15-16, **Seminar and Workshop of Fine and Large Needle Biopsies of the Thyroid Gland.** **Location:** Education and Research Center, Henry Ford Hospital, Detroit. **Sponsor:** Henry Ford Hospital. **For:** All interested physicians. **Cost:** \$250. **Contact:** Medical Education, Henry Ford Hospital, 2799 W. Grand Blvd., Detroit, 48202 (313) 876-1464. **Approved for:** 15½ hours of Category I Credit.

Date: May 17, **Regional Oncology Symposium.** **Location:** General Motors Institute, Flint. **Sponsor:** Hurley Medical Center. **For:** All interested

physicians. **Contact:** Richard D. Garlick, Hurley Medical Center, Sixth Ave. and Begole, Flint 48502 313/766-0142. **Approved for:** 6 hours of Category I Credit.

Date: May 19-23, **Advances in Internal Medicine.** **Location:** Towsley Center, U-M. **Sponsor:** U-M Office of Continuing Medical Education. **Cost:** \$290. **Contact:** Towsley Center for CME, 313/764-2287. **Approved for:** 35 hours of Category I Credit.

Date: May 21, 1980, **Medical Therapy in Family Practice.** **Location:** Saint John Hospital. **Sponsor:** CME Committee of Saint John Hospital. **For:** All interested physicians. **Cost:** \$90. **Contact:** Ms. Linda Radu, Secretary, Continuing Medical Education, Department of Health Education, Saint John Hospital, 22101 Moross Road, Detroit 48236 (313/343-4000). **Approved for:** 8 hours of Category I Credit.

Date: May 27, **Infectious Diseases Symposium.** **Location:** Butterworth Hospital, East Auditorium. **Sponsor:** Butterworth Hospital. **For:** All interested physicians. **Cost:** \$40. **Contact:** Butterworth Hospital Medical Education Office, 100 Michigan, N.E., Grand Rapids, 49503 616/774-1835. **Approved for:** 7 hours of Category I Credit.

Date: May 30-31, **Neurological Update.** **Location:** Education & Research Center, Henry Ford Hospital, Detroit. **Sponsor:** Henry Ford Hospital. **For:** All interested physicians. **Cost:** \$135. **Contact:** Medical Education, Henry Ford Hospital, 2799 W. Grand Blvd., Detroit, 48202 (313) 876-1464. **Approved for:** 12 hours of Category I Credit.

Date: June 5-6, **Blood Banking.** **Location:** Towsley Center, Ann Arbor. **Sponsor:** U-M Office of Continuing Medical Education. **For:** All interested physicians. **Cost:** \$125. **Contact:** Towsley Center for CME, 313/764-2287. **Approved for:** 12½ hours of Category I Credit.

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CLINICAL & ANATOMICAL PATHOLOGIST

The Upjohn Company's Clinical Research Laboratories has an opening for a physician to conduct innovative research using clinical applications of laboratory and tissue measurements for development of investigational drugs. The Pathologist will be an important contributor to the direction of research and marketing efforts as well as provide leadership and influence to internal/external scientific, medical, political and governmental communities. Qualifications require an M.D., board certification in clinical and anatomical pathology with three to five years pathology and/or research experience.

The position together with excellent salary, corporate fringe benefits, regularity of hours and an opportunity to work at the forefront of medical research offers an attractive and meaningful alternative to hospital and private practice.

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An Equal Opportunity Employer M/F

Mastectomy patients have own Lansing shop

By Ellen Louhi Burton, special to Michigan Medicine

Women who have had mastectomies or other shape-changing breast surgery need all the help they can get. Four Lansing-area women, three who have undergone the experience, intend to do something about it.

Suzi Porter, Joan Hess, Mardi Murray and Lenore Shebuski are proprietors of The Front Room Underfashions, Inc., which opened its doors at 104 N. Marshall Street, Lansing, Feb. 4.

They've taken an old apartment and converted it into a charming, informal setting where women who have had mastectomies can be fitted with breast forms that fit precisely.

All of the new entrepreneurs have taken intensive training to become fitting specialists. Their shop also will have a sewing room where expert adjustments can be made pronto to fit the individual.

Basically that's what The Front Room Underfashions, Inc. is all about — individual fitting for individuals who have had breast surgery.

The choice in the marketplace is extremely limited, says Suzi Porter, a successful Lansing real estate broker, and president of the firm. "Fitting the bra is 95 percent of the solution, but expert fitters and bras are not readily available."

When a bra costs from \$100 to \$300, the wrong one can be a costly miscalculation.

The new proprietors estimate that it takes an hour to fit any particular style. They'll carry three breast forms in stock, including a recent West German product. But they'll also have on hand reasonably priced lingerie, including slips, pajamas, robes, matching slippers and gowns. Small pillows which fit under the arm, a helpful asset after surgery, also will be available.

Not surprisingly, help for mastectomy patients isn't being confined to products at the new establishment.

Suzi is putting together a SUPPORT system for cancer patients. Its goal is to help all women be more aware of the need for self-examination. SUPPORT also hopes to identify

crisis points specifically so that the cancer patient can follow them through.

Plans for SUPPORT are mapped out for a year. A central phone number active 24 hours a day, seven days a week, will be publicized.

The Front Room Underfashions, Inc., is located in the UNICEF building at 104 N. Marshall St., Lansing, off Michigan Avenue. Hours are 9 a.m. to 5 p.m. Evening and Sunday fittings will be by appointment.

CATEGORY I/continued

Date: June 5-6, Michigan Occupational Medical Association Annual Meeting. **Location:** Bay Valley Inn, Bay City. **Sponsor:** Michigan Occupational Medical Association. **For:** All interested physicians. **Contact:** Joann Madden, 313/766-3252. **Approved for:** 4 hours of Category I Credit.

Date: June 19-21, 31st Annual Keyport-Gaylord Trauma Symposium. **Location:** Hidden Valley Club, Gaylord. **Sponsor:** Michigan Committee on Trauma, A.C.S. **Cost:** \$30. **Contact:** Theresa Sokol, Dept. of Surgery, Wayne State Univ., 540 E. Canfield, Detroit, 48201. **Approved for:** 12 hours of Category I Credit.

Date: June 22-27, 16th Annual Northern Michigan Summer Conference. **Location:** Shanty Creek, Bellaire. **Sponsor:** U-M Office of Continuing Medical Education. **For:** All interested physicians. **Cost:** \$225. **Contact:** Towsley Center for CME, 313-764-2287. **Approved for:** 21½ hours of Category I Credit.

Date: July 25-27, 1980, EKG Interpretation and Arrhythmia Management. **Location:** Grand Hotel, Mackinac Island. **Sponsor:** International Medical Education Corporation. **For:** All interested physicians. **Cost:** \$215.00. **Contact:** International Medical Education Corporation, Division of Postgraduate Education, Dept. 12, 64 Inverness Drive East, Englewood, CO 80112 (800) 525-8646 Toll Free or (313) 773-1144. **Approved for:** 15 hours of Category I Credit.

Date: July 31-Aug. 3, Michigan Ophthalmological Society Twelfth Annual Summer Conference. **Location:** Grand Hotel, Mackinac Island. **Sponsor:** Michigan Ophthalmological Society. **For:** Ophthalmologists. **Cost:** \$75. **Contact:** Tanya Miller, MSMS headquarters, 517-337-1351. **Approved for:** 7 hours of Category I Credit.

Date: Aug. 22-25, 6th Annual Mackinac Island Conference. **Location:** Grand Hotel, Mackinac Island. **Sponsor:** U-M Office of Continuing Medical Education. **For:** All interested physicians. **Cost:** \$150. **Contact:** Towsley Center for CME, 313/764-2287. **Approved for:** 11 hours of Category I Credit.

Date: Aug. 23-24, Anatomy and Techniques of Regional Anesthesia. **Location:** Wayne State University School of Medicine, Scott Hall, Detroit. **Sponsor:** Wayne State University. **For:** All interested physicians. **Contact:** Wayne State University School of Medicine, Division of Continuing Medical Education, 9B-32 Health Care Institute, Detroit, 48201. **Approved for:** 12 hours of Category I Credit.

Wayne State University School of Medicine Alumni Association 112th Medical Alumni Reunion Day

Wednesday, May 14, 1980
Michigan Inn
Southfield, Michigan

TOPIC:

Sports Medicine

REGISTRATION:

8:30 a.m.-9:00 a.m.

FEES:

\$15.00 for WSU Medical Alumni Assoc. members,
\$30.00, non-members

PROFESSIONAL SESSIONS:

9:10 a.m.-9:45 a.m.

"Quality and Quantity of Exercise
to Maintain Fitness"

9:45 a.m.-10:20 a.m.

"The Physiologic Benefits of
Physical Conditioning"

10:20 a.m.-10:30 a.m.

Coffee Break

10:35 a.m.-11:10 a.m.

"Diagnostic Evaluation and Interpretation
of Exercise Testing"

11:10 a.m.-11:40 a.m.

Panel Discussion

LUNCH:

11:40 a.m.-1:30 p.m.

*(Includes student and distinguished
alumni awards, annual business meeting)*

AFTERNOON SESSIONS:

1:30 p.m.-2:10 p.m.

"Nutritional Aspects of a Fitness Program"

2:10 p.m.-2:50 p.m.

"Maintaining Fitness in the Respiratory Impaired Patient"

2:50 p.m.-3:30 p.m.

"Prevention of Recreational Sport Injuries Through Exercise & Fitness"

3:30 p.m.-4:15 p.m.

Panel Discussion

RECEPTION:

6:00 p.m.

DINNER AND PRESENTATION**OF GOLD AND SILVER****ANNIVERSARY CERTIFICATES:**

7:00 p.m.

*(Dancing and entertainment
will follow dinner)*

5 hours of CME credit in Category 1.

For further information call WSU

School of Medicine (313) 577-1495.

CLINICAL RESEARCH PHYSICIAN

The Upjohn Company's Experimental Medical Research area has an opening for a physician to participate in the conception, design, implementation, execution and analysis of G-I investigational drug development as part of the Digestive System Research Subprogram. Present lines of investigation include G-I antisecretory disease states, intestinal motility and cytoprotection. Qualifications require an M.D. and the equivalent of an internship; clinical practice and medical licensure desirable; pharmaceutical industry drug development experience and broad eligibility preferred also.

The position together with excellent salary, corporate fringe benefits, regularity of hours and an opportunity to work at the forefront of medical research offers an attractive and meaningful alternative to hospital and private practice.

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An Equal Opportunity Employer M/F

Auxiliary members forming speakers bureau

By Donna Chase, Grand Rapids

The news media have been speaking out regarding medicine for some time. Soon MSMS Auxiliary members will have their chance to speak out.

In the fall of 1980, auxiliaries will have an opportunity to work closely with the medical society to establish a speakers bureau training program. This program will train county speakers bureaus to speak out on vital subjects that are in the best interest of medicine, the physician and family.

This is an opportunity for the auxiliary and the doctor to build better public relations in the community as well as present the views of organized medicine.

This is a big undertaking. However, nothing ventured, nothing gained. A start must be made somewhere to promote the fact that the physician and his spouse do care about the high cost of medicine, and that they are interested in public concerns. This can be accomplished by contact with small groups such as the PTA, church and hospital guilds, Rotary clubs, chambers of commerce, junior leagues and senior citizen groups.

Mrs. Chase is president-elect of the MSMS Auxiliary. She will begin her term in May.

The MSMS Auxiliary will raffle an afghan at its annual meeting in May. Several names will be drawn to receive a prize in addition to the afghan. Physicians and spouses may write a check to AMA Educational Research Fund for their ticket.

The auxiliary now has a T-Shirt featuring the Michigan Robin with the words, "Be a Healthy Bird." The cost is \$6 each, with profits going to the AMA-ERF. The shirts are of fine cotton, are machine-washable, and are sized for bigger children and adults. For details on these projects please contact Mrs. George C. Hardie, Michigan AMA-ERF chairman, 3425 Caroline Dr., Jackson, 49203, 517/783-6734.

MSMS is requesting that all auxiliary speakers first take the training session, scheduled Oct. 28-29, before responding to a request for a speech topic. This is to prepare the auxiliaries and to make sure they have current and correct facts plus the know-how to make this important project a success.

The fall training session will provide instructions in speech-making techniques and an opportunity to work before video cameras. The Michigan State Medical Society will provide several speeches or speech outlines for use as a training tool. This package will then be taken to the local area and developed by the auxiliary to meet the needs of the specific city or community.

It is the wish of the MSMS Public Relations Department, the Board of MSMSA and the MSMS Long-Range Planning Committee that every auxiliary in Michigan make plans now to incorporate this speakers bureau project into their plans for next fall.

Involvement will provide the auxiliary an educational experience and much closer working relationships with the state and local medical societies.

This is the opportunity auxiliaries need to step up and speak out for medicine!

The rate for each classified advertisement in *Michigan Medicine* is 15¢ per word, with a minimum charge of \$7.50. Copy for classified advertisements should be received not later than the first of the month preceding the month of publication.

Positions open

General Practitioner — to provide medical care in a small state facility for the mentally retarded, located in a rural setting in Michigan's beautiful Upper Peninsula. Current salary \$49,882 plus a liberal Civil Service fringe benefit package. Limited housing available at moderate cost. Write Steven A. Myers, MD, Chief of Clinical Affairs, Newberry Regional Mental Health Center, Newberry, Michigan 49868.

Family Practitioner — Tampa Bay Area — Florida. Federally qualified HMO is recruiting family practitioners for ambulatory care facilities in Clearwater, Florida. Competitive salary and comprehensive benefit program with opportunity to participate in academic program available. If team interaction and casual living appeal to you, send CV to: Prepaid Health Care, Inc., ATT: Jerry Williamson, MD, 1417 South Belcher Road, Clearwater, Florida 33516. (813)-535-3474.

Internist — Tampa Bay Area — Florida. Prepaid Health Care, Inc., a federally qualified HMO, is recruiting internists, BE or BC, for adult ambulatory care units in Clearwater and St. Petersburg. Excellent salary and benefit programs, with opportunity to participate in academic program available. Progressive, growing community. If interested in growing with us, send CV to Jerry Williamson, MD, Medical Director, 1417 South Belcher Road, Clearwater, Florida 33516. (813)-535-3474.

Positions With The State Of Michigan — Currently taking applications for positions expected to be available in the future. Primarily interested in board certified or board eligible internists with cardiology background. Office locations in Southfield, Lansing, and Traverse City. Also considering an office in Kalamazoo. Salary in 50's with approximately 23% fringe benefits. An equal opportunity employer. All enquiries treated confidentially. For further details please write: Disability Determination Service, P.O. Box 30011, Lansing, MI 48909, or call collect: Harry D. Nesmith, MD, Chief Medical Consultant (517) 373-7830. In Michigan, call toll free 1-800-292-2710.

Psychiatrists — Northeast Michigan Community Mental Health Services Board has immediate openings for full-time psychiatrists licensed or eligible for licensure in the state of Michigan. Position located in the beautiful northern region of lower Michigan offering attractive cultural, social and year-round recreational opportunities. Position involves working in a well-established community mental health clinic serving a four county area, clinical supervision of agency clients and staff on an outpatient basis and access to a 27-bed inpatient psychiatric unit in a local general hospital (currently undergoing \$15 million expansion program), involving acute and chronic emotionally and mentally impaired clients. Excellent opportunity for professional growth and

development. Salary \$54,000 to \$60,000 with excellent fringe benefits including educational leave, disability, life, malpractice and health insurances. Call collect or send vita to Paul VanDerSchrie, Director, Northeast Michigan Community Mental Health Services Board, 630 Walnut Street, Alpena, Michigan 49707. Phone (517) 356-2161. Equal opportunity employer.

General Surgeon — North Carolina. Needed for University owned hospital in small coastal town. This private practice opportunity is ideal for an experienced General Surgeon who would enjoy a relaxed, productive life style in a desirable climate on the coast. Send CV to MSMS, Box 20, 120 W. Saginaw, East Lansing, MI 48823.

Part-Time Physician Needed to do routine physicals to assess donor suitability for plasmapheresis. Good job for older physician looking to slow down. Malpractice coverage provided. Contact Doug Klynstra or Debra White at American Plasma Management, East Lansing. Phone 517-351-2620.

Internist with interest in cardiology, to join long established practice in rural community within 30 miles of large shopping areas. Active coronary care unit, excellent hospital and office facilities. Opportunity to become rapidly established in a busy practice with no investment. All Corporation fringes. Please call Area Code 517-846-6122 days or 846-4620 evenings, or write Malcolm K. Dolbee, MD, P.C., P.O. Box 09, Standish, Michigan 48658.

Thinking Of Retiring? Any age physician, medical directorships available across the USA. All valid licenses, when able to relocate. Salary \$30,000.00 per year, 35 hours per week, malpractice insurance paid. If physician is not retired and desires a new practice opportunity, please send curriculum vitae, site location, salary, date able to relocate. Write: Fred Trachovina, DO, 1000 Second Ave., South Minneapolis, Minnesota 55403 or call: 612-32-7938.

Multi Specialty Clinic In Northern Michigan recruiting for following Specialties: Internal medicine, Family Practice, Urology, Orthopedics, Ophthalmology, Obstetrics & Gynecology. Excellent opportunity with exceptional first year guarantee — will negotiate. Contact: John Crowder, Emergency Consultants Inc., One Windemere Place, Petoskey, MI 49770. (616) 47-1580. Out-of-state, (800) 253-7092.

Family Practitioners: To expand central core of primary care physicians in well established southeastern Wisconsin multi-specialty clinic. 10 miles from Milwaukee. Excellent recreation area. \$45,000 first year salary, with additional incentive plan and many other fringe benefits. Excellent opportunity. Send CV to Recruitment Committee, Burlington Clinic, S.C., Box 40, Burlington, WI 53105.

Urologist Position available at progressive A Medical Center located in Michigan's upper peninsula. Board certified candidates are preferred. The community offers ideal family living in town of 18,000 people with good schools, year-round sportman's area with excellent hunting, fishing and winter sports. Well equipped 214-bed GM&S medical center offering competitive salary and benefits. Applicants must meet required spoken and written English proficiency. Write: Chief of Staff, VA Medical Center, Iron Mountain, MI 49801 or call: (906) 774-3300, Ext. 227. Allowable moving expenses paid. Equal opportunity employer.

Student Oriented Health Service serving 7,500 technical student population seeks primary care physician. Outpatient clinic, shared call. Liberal fringes, competitive wage. Contact: J. L. Anderson, MD, Director, MTU Health Service, Houghton, MI 49931, or call 906-487-2435. Michigan Technological University is an Equal Opportunity Educational Institution/Equal Opportunity Employer.

General/Family Practice Physician. For group of five clinics in Detroit innercity and suburbs. Plenty of professional freedom. Hours 10 a.m. to 6 p.m. with hospital optional. Malpractice, medical, dental, life and disability insurance paid, also auto allowance. Trail Clinics, 16840 E. Warren, Detroit. (313) 882-7060 Cindy Thompson.

Marquette, Michigan. Urologist needed immediately or in the near future to replace urologist in a two man practice. Marquette is a university community on the unspoiled south shore of Lake Superior. Admitting privileges at Marquette General Hospital offering regional medical care for people in the central area of the Upper Peninsula. 18 bed urologic unit, fully equipped hospital with advanced lab facilities; ultrasound, CT scanner; excellent radiologic service. Hospital has a young and excellently trained nephrologist; active cardiovascular surgery service. Current staff of 79 solo and a small group of private practice practitioners. 87% board certified, average age of active staff is 42 years. Please contact: John D. Wojcik, MD, Marquette General Hospital, 420 West Magnetic Street, Marquette, Michigan 49855. Phone: 906-228-9440.

Emergency Medicine Positions: available with Emergency Physician Group throughout Michigan, PA, NY, NJ, and Southeastern U.S. including all suburban, rural and metropolitan areas. Fee-for-services with minimum guarantee provided. Malpractice paid. Practice credits toward board certification. Please send resume to: NEEMA Emergency Medical, Ste. 400, 399 Market St., Philadelphia, PA 19106. In Pennsylvania, call 215-925-3511, those outside Pennsylvania call 1-800-523-0776.

Miscellaneous

Lake Property In Caseville. 10 acres, 360 foot frontage, \$100,000. Evenings 313-769-1123.

Sanibel Island, Fla. Luxurious 2 bedroom, 2 bath condominiums on Gulf. Completely furnished including linens. Miles of uncrowded white sand beaches, fringed by lush tropical foliage, wild flowers, graceful sea oats and flowering trees. All amenities including pool, tennis, golfing, fishing, boating, sailing, bicycling and bird watching. Weekly, monthly discount. 313-645-5498.

Indian Lake Estates — 2 story Tudor with beautiful interior wood accents. Great for entertaining. Equipped kitchen, carpeting, air conditioning, fireplace, full length deck overlooking unique wooded setting. Four bedrooms, two full baths plus two half baths. First floor laundry. Full basement, 2 car garage. Fully landscaped. By owner — 332-0430. Okemos.

Available for Lease or sharing fully equipped physicians office in excellent locality — Grand River, East Lansing — Also physician's office equipment, furniture, instruments for sale. Tel. 351-9097.

St. Thomas, U.S.V.I. — Condominium apartment. Ocean front. Sleeps 4-6. Free tennis, three pools, duty free shopping. List of local medical meetings available. 313/543-2970 or 542-7600.

Traverse City Michigan — Plenty of glass, magnificent modern 4 bedroom, 3 bathrooms, 2 fireplace home, living room, dining room, family room overlooking Lake Leelanau on Timberlee ski resort. Weekly or monthly, open December thru April. Call Cindy Thompson 313-882-7060 or write 16840 E. Warren, Detroit, MI 48224.

Medical And Dental Office under construction — 1000 sq. ft. suite available — 4147 Sixteen Mile Road, 2 blocks east of Ryan, Sterling Heights. Call B. Monast at 313/542-7100.



"How was the vacation, Miss Hibbs?"

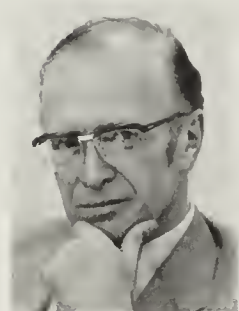
Questions on a wide variety of topics are asked daily of MSMS staff and leaders. They in turn draw on many expert resources to help MSMS members get good information. To better inform the membership, sample questions, with answers, are printed here. Future issues will carry more.



FOR: Mary Jo Dwyer, Assistant Director of Reference Services, AMA Division of Library and Archival Services

"I am a Michigan cardiologist. I have a heart patient traveling soon to Spain. I would like to assure this patient has the care of a competent cardiologist in that country. How can I do this?"

Our library has a reference staff of seven persons which handles approximately 5,000 reference requests per month. We frequently handle requests of this type. In your case, Doctor, we consult the *AMA Directory of Medical Specialists*, which has a list of American-certified specialists in Spain at the end of the geographical listing in the internal medicine/cardiology section. We will supply you with this list. We would also suggest you contact the International Association for Medical Assistance to Travelers in New York City, which can give you the names of English-speaking physicians in Spain who are cognizant of Americans' drug-using idiosyncrasies. These physicians are not necessarily American certified, but could be helpful.



Doctor Ylvisaker

FOR: John R. Ylvisaker, MD, Chairman, MSMS Board of Managers

"I recall MSMS planned to fill the new Stockwell Building at MSMS headquarters with appropriate tenants. Is the building at capacity now, and who do we have joining our MSMS staff at the headquarters in East Lansing?"

MSMS has nearly filled the Stockwell Building at this time, with just one office suite left to rent. The major renter is the Michigan Physicians Mutual Liability Company, the MSMS-founded professional liability insurance company for members. MPMLC has the entire top floor of the two-story Stockwell Building. The MSMS-founded Physicians Service Group Inc., has twenty percent of the building, and provides administrative services to several specialty societies, as well as to several MSMS membership benefit programs. Other tenants include the Statewide Professional Standards Review Council, the Michigan Chapter of the American College of Emergency Physicians, the American Board of Emergency Medicine, and a law firm.

FOR: Thomas Oelrich, PhD, Ann Arbor, U-M Professor of Anatomy Head, Anatomical Donor Program

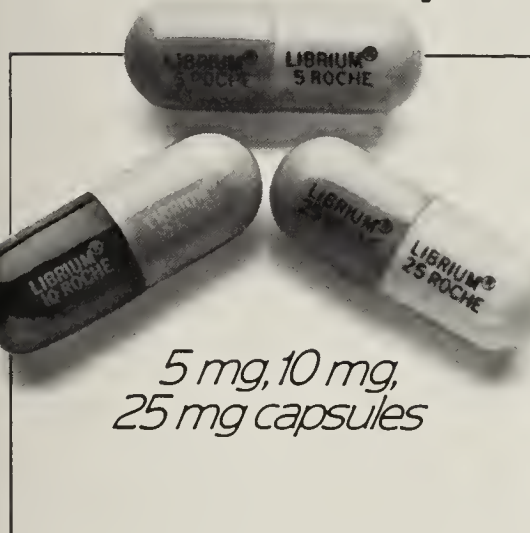
"I would like to sell my body for medical research purposes. Is this possible? Are bodies ever rejected for medical research and education purposes?"

Michigan's medical schools, which are the sole user of cadavers for medical research and education programs, do not need to purchase bodies, as they have an adequate supply from donors. Bodies are rejected if they are autopsied, burned or mutilated. Those wishing to donate their bodies for medical research should contact the University of Michigan Medical School, Michigan State University College of Human Medicine, or Wayne State University School of Medicine.



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Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Warn patients that mental and/or physical abilities required for tasks such as driving or operating machinery may be impaired, as may be mental alertness in children, and that concomitant use with alcohol or CNS depressants may have an additive effect. Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported.

Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and

acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

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MAY 19 1980

Vol. 79, No. 12
April 30, 1980

MEDIGRAM

Breaking News for Michigan Doctors

Doctor Ylvisaker installed; Doctor Fryfogle elected

MSMS delegates, at their 1980 annual meeting, April 25-27, installed Pontiac surgeon John R. Ylvisaker, MD, as president. Doctor Ylvisaker, who was MSMS treasurer for 12 years, succeeds Ernest P. Griffin, Jr., MD, Flint radiologist.

The delegates elected James D. Fryfogle, MD, Detroit thoracic surgeon, president-elect. Doctor Fryfogle, who will assume the presidency in May, 1981, has been speaker of the MSMS House of Delegates the past four years, and is past president of the Wayne County Medical Society.

Doctor Ylvisaker was installed, and Doctor Fryfogle elected, in ceremonies at the 115th annual session of the MSMS House of Delegates at the Michigan Inn, Southfield.

MSMS Council elections saw Louis R. Zako, MD, Dearborn Heights family physician, re-elected chairman of the MSMS Council, and Thomas R. Berglund, MD, Portage family physician, elected Council vice chairman.

Elected speaker of the House of Delegates, to succeed Doctor Fryfogle, was David Siegel, MD, Lansing urologist, who has served the past four years as vice speaker. New vice speaker is Gerald H. Mandell, MD, Detroit pathologist.

Other MSMS officers elected by the Delegates at the Southfield meeting are Robert M. Leitch, MD, Battle Creek, to

MSMS delegates take action

The MSMS House of Delegates, meeting in annual session April 25-27 at the Michigan Inn, Southfield...

---Called for a major MSMS study of the validity of the Michigan hospital bed reduction program and for MSMS to develop an alternative plan if needed;

---Called for MSMS to seek repeal of the state law mandating second surgical opinions and directed the Medicaid Liaison Committee to address the problems of second surgical opinion programs;

---Adopted a five-part MSMS public relations effort to begin in 1980-81 and approved a \$10 dues increase to cover the initial costs of the program.

These were among the major actions of the 213 delegates seated for the annual session. They also installed John R. Ylvisaker, MD, Pontiac surgeon, as MSMS president, and elected James D. Fryfogle, MD, Southfield thoracic surgeon, as president-elect.

Highlights of the annual House of Delegates meeting also included special awards ceremonies, a forum on medical cost control featuring past AMA president Edward R. Annis, MD, and a Michigan Doctors Political Action Committee luncheon. Speakers at the MDPAC luncheon were Lt. Gov. James H. Brickley, and St. Sen. Douglas Ross (D-Oak Park).

Little controversy arose over issues brought before the delegates, who smoothly concluded their business shortly after noon Sunday.

Following is a summary of their actions:

Government programs

THE DELEGATES CALLED for MSMS to seek a moratorium on the implementation of any bed reduction process until the MSMS study takes place and alternative plan, if needed, is developed.

They commended the legislature for its 90-day moratorium on implementation of the bed reduction program and voted to transmit a copy of their six-part bed reduction resolution to the legislature's bed reduction oversight committee.

(continued on back page)

(continued on page 2)

The MSMS bed reduction study is to examine "the validity of the Michigan program, the criteria used, and the probable impact of such a plan on the cost, delivery and availability of medical care in Michigan." The possible MSMS alternative plan "must contribute to cost containment," voted the delegates, "and have no adverse impact on the quality and availability of medical care in Michigan."

THE HOUSE SUPPORTED the Michigan Emergency Services Health (MESH) Council on the condition it reconstitute as a consortium of health provider organizations. The House voted to make information available to aid the MESH Council.

THE HOUSE SUPPORTED MSMS members who are involved in PSRO efforts and further encouraged its members to become involved in physician-controlled and directed peer review.

THE HOUSE RESOLVED to intensify its efforts to prevent extension of certificate of need (CON) requirements to physician's private offices, by calling, if necessary, on new Michigan Department of Public Health rules differentiating free-standing, outpatient surgical clinics from private physicians' offices.

Legislation

THE HOUSE CONTINUED to oppose all mandatory second surgical opinion programs "as not being in the best interest of the public." The House voted to seek repeal of the section of PA 110 of 1979 which mandates such programs, and called on the MSMS Council to direct the Medicaid Liaison Committee to study the following problems of mandatory second surgical opinion programs:

- (1) undue delays in consultation
- (2) interference with the patient/physician relationship
- (3) discrimination against the disadvantaged of our society, and
- (4) improper restriction of indicated surgical procedures.

THE HOUSE VOTED to support and publicize the current petition drive (deadline is May 15) to repeal the Single Business Tax,

asked the Council to "take whatever means are available to support repeal of the tax" and urged other service-oriented professions to join with MSMS in this effort.

THE HOUSE COMMENDED the Michigan Board of Medicine for simplifying the CME reporting requirements and urged MSMS members to cooperate fully if their CME credits are audited.

THE MSMS DELEGATES URGED the Michigan delegation to the AMA to seek federal legislation like Michigan's to protect the integrity and privacy of peer review work and records.

THE HOUSE VOTED to seek uniform and equitable rules for MDs and DOs pertaining to amphetamines.

THE HOUSE EXPRESSED its concern with the governor's proposed public health budget cuts.

THE HOUSE ASKED the MSMS Council to bring the Attorney General's recent opinion, #5498, on physician ownership of health care facilities and services, to the attention of the legislature so that any necessary steps may be taken to modify the effects of that opinion.

THE HOUSE SUPPORTED SB 394 encouraging the use of seat belts and car seats for children through tax credits for their purchase.

Public relations

THE 1980 DELEGATES EXPANDED on their 1979 call for an educational and informational campaign emphasizing the positive aspects of the present medical care system. In 1979, they instructed The Council to review all facets of public relations and recommend to the 1980 meeting specific proposals, with their fiscal impact, for increased activity.

The public relations proposals, adopted by the House this year, call for cable television programs, public service radio messages, a news feature service, public exhibits and folders, and a research project to determine public at-

titudes toward Michigan MDs.

The delegates approved the Ways and Means Committee's recommendation for a \$10 dues increase to fund the public relations campaign. The dues increase will take effect with the 1981 dues billings.

Public health

THE HOUSE RESOLVED "that MSMS identify those health problems endemic in the Indochinese refugee population and develop diagnostic and treatment alternatives for these health problems, which shall be made available to Michigan physicians, as well as to the AMA and other state medical societies."

The House further resolved that MSMS cooperate with the Michigan Department of Public Health to identify health problems of other refugee groups.

THE HOUSE ASKED the MSMS Council to investigate, monitor, and if necessary, oppose Development Assessment Centers to screen childhood disorders. The House was concerned with the cost of establishing such centers instead of providing the services through existing physicians' offices.

THE HOUSE URGED MSMS and county medical societies to revitalize committees on aging, and charged these committees "with re-examining the status of senior citizens in all communities, and assuming the advocacy role for good health, preventive programs and adequate care" for the aged.

THE HOUSE CALLED on official MSMS publications to identify marijuana smoking to physicians "as a front-rank public health problem, and an agent of potentially severe adverse effect on individuals and on society," and to consider appropriate public communications to identify the hazards to individuals.

Third party payors

To eliminate public confusion, THE DELEGATES VOTED to ask the Michigan insurance commissioner "to require all health insurance carriers doing business in the state to publicize to their policyholders

the limits, as well as the benefits of such policies."

THE HOUSE REAFFIRMED that "only physicians should make medical decisions concerning patients. Furthermore, third party payors should pay for the services of paramedical providers only when these services have been specifically ordered by a physician."

THE DELEGATES ASKED the MSMS Council to investigate the possibility of establishing a separate organization to deal with third party payors in their relationships both with physicians' and patients' financial health concerns. The delegates asked for a report on this investigation at their 1981 meeting.

Miscellaneous

THE DELEGATES REAFFIRMED their position calling for MDs to serve on hospital governing boards and resolved to seek Michigan Hospital Association support of their stand. They further resolved to poll Michigan hospital chiefs of staff to determine the type and prevalence of physicians on hospital boards.

THE DELEGATES WENT ON RECORD favoring a single body to oversee and accredit CME programs, and called on the AMA to continue discussion with the LCCME to establish a single national CME accrediting body.

THE DELEGATES VOTED to send the MSMS official newsletter, Michigan Medicine/Medigram, and other pertinent materials, to all Michigan medical students.

THE DELEGATES RESOLVED to work through the Michigan delegation to the AMA to resist any encroachments on the right to establish standards of ethical behavior "for the guidance of those who wish to become members."

Constitution and bylaws

THE COMMITTEE APPROVED on final reading the formation of the Schoolcraft County Medical Society, separate from Delta County Medical Society.

continue as secretary; W. E. Maldonado, MD, Lansing, new assistant secretary to succeed Kenneth H. Johnson, MD, Lansing; Leland E. Holly II, MD, Muskegon, to continue as treasurer, and Dean P. Carron, MD, to continue as assistant treasurer.

In other elections, Richard J. McMurray, MD, Flint; Robert E. Rice, MD, Greenville; and Frank B. Walker, MD, Grosse Pointe Farms, were re-elected delegates to the AMA. Newly-elected delegates are Robert D. Burton, MD, Grand Rapids, to replace Brooker L. Masters, who chose not to run again for the delegation; and Robert D. Allaben, MD, Detroit, to fill the unexpired term of Lee B. Stevenson, MD, Livonia, who resigned from the delegation.

Elected as alternate delegates to replace Doctors Allaben and Burton, were Jay K. Harness, MD, Chelsea, and Louis R. Zako, MD, Dearborn Heights. Re-elected as alternate AMA delegates are Richard H. Gascoigne, MD, Adrian, and George M. Wilson, MD, Marquette.

Delegates honor Michigan physicians

The 1980 MSMS House of Delegates honored 29 Michigan physicians who have served an aggregate 1,450 years as physicians since their graduation from medical school 50 years ago.

MSMS 50-year pins were presented to those special awardees in ceremonies April 26 at the Michigan Inn. Among them was Orlen J. Johnson, MD, Bay City, past MSMS president.

The MSMS delegates recognized a number of other outstanding Michigan physicians. Presidential citations were awarded by 1979-80 MSMS President Ernest P. Griffin, Jr., MD, to John R. Wilson, MD, immediate past president of the Michigan Board of Medicine, and to 11 MDs who have served five or more years in health planning.

They were William C. Bock, MD, St. Joseph; Zane A. Brashares, MD, Brooklyn; Stuart L. Cohn, MD, Alpena; James D. Fryfogle, MD, Southfield; D. Bonta Hiscoe, MD, East Lansing; William O. Mays, MD, Bloomfield Hills; Joseph R. Montante, MD, Orchard Lake; Richard J. Potter, MD, Negaunee; Winston B. Prothro, MD, Haslett; James F. Tobin, MD, Ishpeming, and Ian D. Wilson, MD, Petoskey.

Citations were presented to Michigan MDs who are presidents of national medical organizations: Mohammed N. Akhter, MD, Lansing, American College of International Physicians; Joseph C. Honet, MD, Detroit, American Academy of Physical Medicine and Rehabilitation; Francis L. Purcell, MD, Ypsilanti, American Occupational Medical Association; E. Emerick Szilagyi, MD, Detroit, Western Surgical Society; Frank B. Walker, MD, Grosse Pointe Farms, American Society of Clinical Pathologists, and Sherwood B. Winslow, MD, Battle Creek, Collier Surgical Society.

Michigan State Medical Society
120 West Saginaw Street
East Lansing, Michigan 48823

MICHIGAN MEDICINE

Vol. 79 No. 12, April 30, 1980

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Editor: Judith Marr

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MAY 29 1980

Breaking News for Michigan Doctors

NOTABLE COMING EVENTS...

May 13--Spring seminar and litigation conference, Michigan Association of the Professions, at Kellogg Center, East Lansing, contact MAP, 1407 S. Harrison Road, Box 946, East Lansing, 48823.

May 17-18--Negotiations seminar, jointly sponsored by Oakland County Medical Society and AMA, at the Michigan Inn, Southfield, contact John B. Bryan, MD, 313/288-6240.

May 20--"Health Education for Children Day," part of 1980 Michigan Week observance. Sponsors are Michigan Health Council and Coalition of Michigan Health Education Associations. Contact Herbert Auer, MHC, 517/337-1615.

May 22--Public hearing on rules pertaining to refund of fees, sponsored by Michigan Department of Licensing and Regulation, at DLR Conference Room B, 320 N. Washington, Lansing, contact DLR Office of Consumer Information, Box 30018, Lansing, 48909.

May 28--Annual Gull Lake Conference, MSMS Committee on Maternal and Perinatal Health, at Gull Lake Conference Center, contact Katie Brewbaker at MSMS headquarters.

Sept. 10-18--MSMS "Swiss Adventure" in group travel, contact Marcelyn Ireland at MSMS headquarters.

Sept. 19-29--MSMS "China Adventure" in group travel, contact Marcelyn Ireland at MSMS headquarters.

MEDIGRAM

MSMS Council highlights

The MSMS Council, at its April 25 and 27 meetings:

- 1) Appointed a new MSMS Task Force on Nursing, comprised of H. Richard Henderson, MD, Warren; Charles L. Seifert, MD, Kalamazoo, and one other person (to be named later).
- 2) Approved a statement on joint practice prepared by MSMS and Michigan Nurses Association representatives working through the Michigan Joint Practice Commission.
- 3) Approved a statement on nurse midwifery prepared by the MSMS Committee on Maternal and Perinatal Health and the Michigan Chapter, American College of Obstetricians and Gynecologists, and authorized transmittal of the statement to the Boards of nursing and nursing specialties and to the new MSMS Task Force on Nursing.
- 4) Recommended the House of Delegates adopt a five-part public relations program developed by MSMS consultants for implementation in 1980-81.
- 5) Approved a new Liaison Committee with the Michigan Hospital Association including Ernest P. Griffin, Jr., MD, immediate past MSMS president; Louis E. Heideman, MD, past president, and John R. Ylvisaker, MD, MSMS president, chairman.
- 6) Re-elected Louis R. Zako, MD, Dearborn Heights, to serve as Council chairman, and elected Thomas R. Berglund, MD, Portage, to serve as vice chairman.
- 7) Elected Robert J. Toteff, MD, Saginaw, to serve as chairman of the Council's reference committee on scientific and educational affairs; re-elected Dean P. Carron, MD, to serve as chairman of the Council's reference committee on finance, and Charles L. Oppy, MD, to serve as chairman of the Council's reference committee on legislative policy.

MSMS prepares for June 2 trial

MSMS legal counsel is making massive preparations for the June 2 trial in Washington in which the Federal Trade Commission will try to prove MSMS is guilty of illegal activities concerning third party payors. An MSMS request for a delay in the trial was denied by a federal judge. MSMS has, however, until Aug. 22 to prepare, as the FTC's case will be heard first.

LEGISLATIVE ACTION...

On May 6, the Senate Commerce Committee began reconsidering HB 4555, with indications it will strive toward reporting a bill to the Senate floor. It already has adopted a substitute for all sections except the fifth, on cost containment. MSMS, the Michigan Hospital Association and the "Shelton Cost Containment Coalition" concurred with some changes expected to be approved by the committee. Meanwhile, more than 40 amendments were awaiting committee action on the remainder of the bill. . . The Senate Health and Social Services Committee scheduled hearings on SB 374, which would amend the Public Health Code requirement that physicians must annually obtain a Drug Control License if they routinely dispense medicines to patients. . . The legislature is seeking to recess for the summer by July 4, but budget bills may delay that schedule.

RESULTS OF ANNUAL Wayne County Medical Society elections will be announced at the June 9 annual meeting at WCMS headquarters. Running for president-elect are Robert W. Black, MD, Detroit internist, and Sidney E. Kobernick, MD, Detroit pathologist.

State, Medicaid budgets short

New projections show the state budget will be short \$300 million this fiscal year, or \$100 million more than the most dire earlier predictions. The state now is tapping its fourth quarter Medicaid budget, which means Medicaid may run out of money by August or September. The director of the Department of Management and Budget predicts the current state recession will last at least two years, and that 25 percent of those persons whose jobs are terminated will have to leave Michigan to find employment. Further bad news is that the Congress is stalling on appropriating the funds needed to keep the food stamp program going, with a May 15 deadline for those appropriations. Benefits could be cut off until the appropriation is approved, particularly in Michigan, which cannot make up for the lost federal revenues.

Debedding oversight committee meets

The Joint Legislative Oversight Committee to review the CHPC-SEM bed reduction plan has held two organizational meetings in the last two weeks. The tentative work schedule for the committee includes meeting on May 12 and 19, June 2, 16, 23 and 30 and a public hearing in Detroit on June 9.

The 16-member Oversight Committee is co-chaired by Rep. Raymond Hood and Sen. Edward Pierce, MD. Other committee members include Reps. Barbara-Rose Collins, Gary Vanek, Wilbur Brotherton, William Bryant, Bela Kennedy, David Evans and Jeffrey Padden and Sens. David Holmes, Michael O'Brien, Donald Bishop, Robert Geake, Bill Huffman, James DeSana and Gilbert DiNello.

NOTICE: Michigan Heart Association's Annual Heart Days, "Cardiovascular Implications for the 80's," scheduled May 22-23 at the Hyatt Regency Dearborn, has been cancelled.

Michigan State Medical Society
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May 1980

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Vol. 79, No. 14

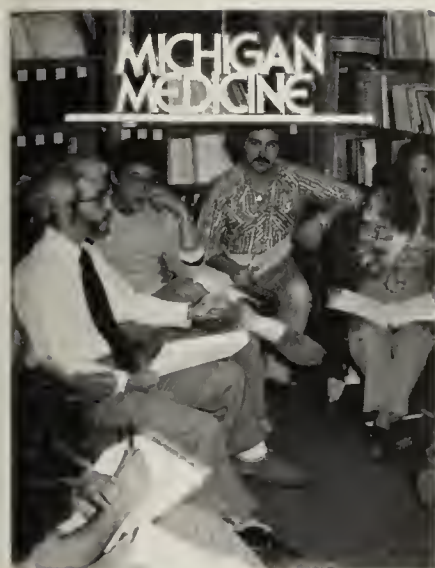


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Michigan Society of Respiratory Therapists	Caroline Rich
MSMS Committee Meeting Schedule	Katie Brewbaker
MSMS House of Delegates	
Agenda and Schedule	Dick Campau
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Students at Michigan State University's College of Human Medicine are featured on the cover of this month's issue. The special report beginning on page 238 provides statistics on Michigan's medical students today, a profile of modern medical students, and short essays by leaders at the three medical schools. (Cover photo by Mert Scholten, MSMS staff)

MICHIGAN MEDICINE

May 1980, Volume 79, Number 14

Special report

- 238** Graduating students at Michigan's three medical schools speak up this month on major medical issues as they see them, and on the physician's future role. The assistant dean for student affairs at Wayne State University describes today's medical student. Women medical students are slowly gaining in numbers and percentages; Charles C. Vincent, MD; Robert Pacer; Michael H. Zaroukian, MD; Michael W. Klinkner, and Elmer White

Features

- 246** The pertinent details for Michigan physicians on the Blues' new reimbursement plan; John A. Richards
- 251** New feature: Peer review exchange; Daniel J. Fall, MD
- 254** Report and photo layout on the 1980 MSMS Maternal and Perinatal Health Conference; Judith Marr, Mert Scholten
- 264** Better communications would improve things between psychiatrists, other MDs; Willah Weddon

Departments

- 232** Editorial
- 233** Medico-legal
- 236** Health planning update
- 258** Views; Craig L. Kippels, MBA, and Frankie Perry, RN
- 268** News
- 271** New members
- 272** Ad index
- 274** Meetings
- 278** Category I courses
- 282** Committees
- 284** Deaths
- 285** Classified
- 286** President's page

Information on Michigan's three medical schools fills one-third of the editorial pages of this month's *Michigan Medicine*.

For good reason, of course. The state's three medical schools (University of Michigan Medical School, Wayne State University School of Medicine and Michigan State University College of Human Medicine, in chronological order) provide the majority of the state's new physicians each year. In recent years, with the public's request for a greater physician/population ratio, the medical schools have graduated increasing numbers of students.

MSMS has expressed its concern and interest in our medical schools through a variety of House of Delegates resolutions during the past decades, and channels members' donations to the medical schools through the Michigan Foundation for Medical and Health Education and the AMA Education and Research Fund.

Each medical school is entitled to a student delegate to the annual MSMS House of Delegates meetings, and the deans of the medical schools are delegates at large if they are MSMS members.

There are over 2,500 medical students in Michigan's medical schools. That's 1,026 at Wayne, 1,063 at Michigan, and 429 at MSU. Together they graduate over 600 students per year, the majority of which remain in Michigan. (At Wayne, 72 percent of the 1979 graduates chose to remain in Michigan. At MSU, 52 percent chose to remain. Of this year's graduating class at the U-M Medical School, 45 percent have elected to remain in the state. These figures come from Sandra Tencza, executive director, Michigan Medical Schools Council of Deans.) And it is important to the practicing physicians of the state to know something about their newly-graduated counterparts.

Therefore, this issue includes statistics, one associate dean's view of his medical students, and three essays by leaders at each of the medical schools themselves. Their views are revealing and provide portents of the directions physicians will take on the issues of the future.

Each of the three students (all graduating seniors) speaks of national health insurance, but their views range from outright support to disdain of any NHI system.

The students call for more patient education by physicians, for more emphasis on primary care, for less "doing" and more "thinking" in delivery of medical care. They ask for an equal balance between curing and caring. They articulate some of the major problems in selection and training of future physicians in this state, as does the associate dean in his article.

Together, they provide the state's physicians with an impression of concerned, caring, committed individuals on the threshold of medical care delivery.

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Michigan Medicine, the official journal of the Michigan State Medical Society, is dedicated to provide useful information for Michigan physicians about actions of the Michigan State Medical Society and contemporary issues, with special emphasis on socio-economics, legislation and new developments in medicine in Michigan. Major medical developments will be reported and interpreted as has been the custom.

The Michigan State Medical Society Committee on Publications is the editorial board of *Michigan Medicine* and advises the editors in the conduct and policy of the magazine, subject to the policies of the MSMS Council.

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If patient requests, MD must respond to attending physician statement

The MSMS Judicial Commission has ruled that a physician is obligated to respond to an insurance company for a patient, at the patient's request and with the proper patient consent form.

The Judicial Commission also ruled that if the fee suggested for the attending physician is too low the insurance company should be so informed and billed for the proper amount.

The Judicial Commission made the decision after consulting with MSMS legal counsel, at the direction of a 1979 MSMS House of Delegates resolution. That resolution asked

MSMS to research the issue of the physician's responsibility to respond to an insurance company's attending physician statement.

MSMS Legal Counsel A. Stewart Kerr's memorandum on the issue says, "Clearly, there is a responsibility to respond, if the patient or expatient desires the insurance coverage." The physician should insist upon a written consent from the patient for disclosure of the information, he says.

"The more difficult problem is whether the physician-patient privilege inhibits the disclosure of the confidential record to a third person and to what extent that privilege is waived by the patient's knowledge that the physician is put in the position of disclosing such confidential information. Our precise problem has not been adjudicated in Michigan," Mr. Kerr notes.

"On balance," he says, "the

privilege in Michigan — a qualified privilege — should yield to critical public and private interests and we would hope that this becomes recognizable Michigan law.

"In summary, and in the absence of definitive law, we believe the Michigan physician who supplies a medical report to an insurer because the patient or expatient has applied for insurance with that insurer, is probably not in legal jeopardy."

Legal counsel chose not to address the payment issue directly, "as there is no Michigan guidance on this other than ordinary principles of contract law."

"Perhaps if the physician does not accept the insurance company fee," says Mr. Kerr, "his legal position is slightly better than if he had contracted, for the fee, to supply the report. This is speculative and really does not bear upon the main question."

These Michigan cases summarized in AMA's Citation

(Please see issue cited for further details.)

"Hospital Not Liable For Failure To Take X-rays," Michigan Court of Appeals, Feb. 22, 1979, from the Citation, Vol. 40, No. 5.

"Michigan Dentistry Board Properly Promulgated Rules For Assistants," Michigan Court of Appeals, April 2, 1979, from the Citation, Vol. 40, No. 6.

"Suit Filed 7 Years After MD Prescribed Drugs Is Not Barred By Time Limit," Michigan Court of Appeals, March 20, 1979, from the Citation, Vol. 40, No. 7.

"Good Samaritan Statute Does Not Apply to Emergency Situation in Hospital, Court Says," Michigan Court of Appeals, Aug. 6, 1979, from the Citation, Vol. 40, No. 9.

"Child Paralyzed At Birth Loses Suit Against Hospital," Michigan Court of Appeals, July 9, 1979, from the Citation, Vol. 40, No. 9.

Malpractice screening panels no panacea

Plaintiffs' lawyers in Missouri have successfully challenged state screening panels in medical malpractice cases. Challenge has now been extended to three other states.

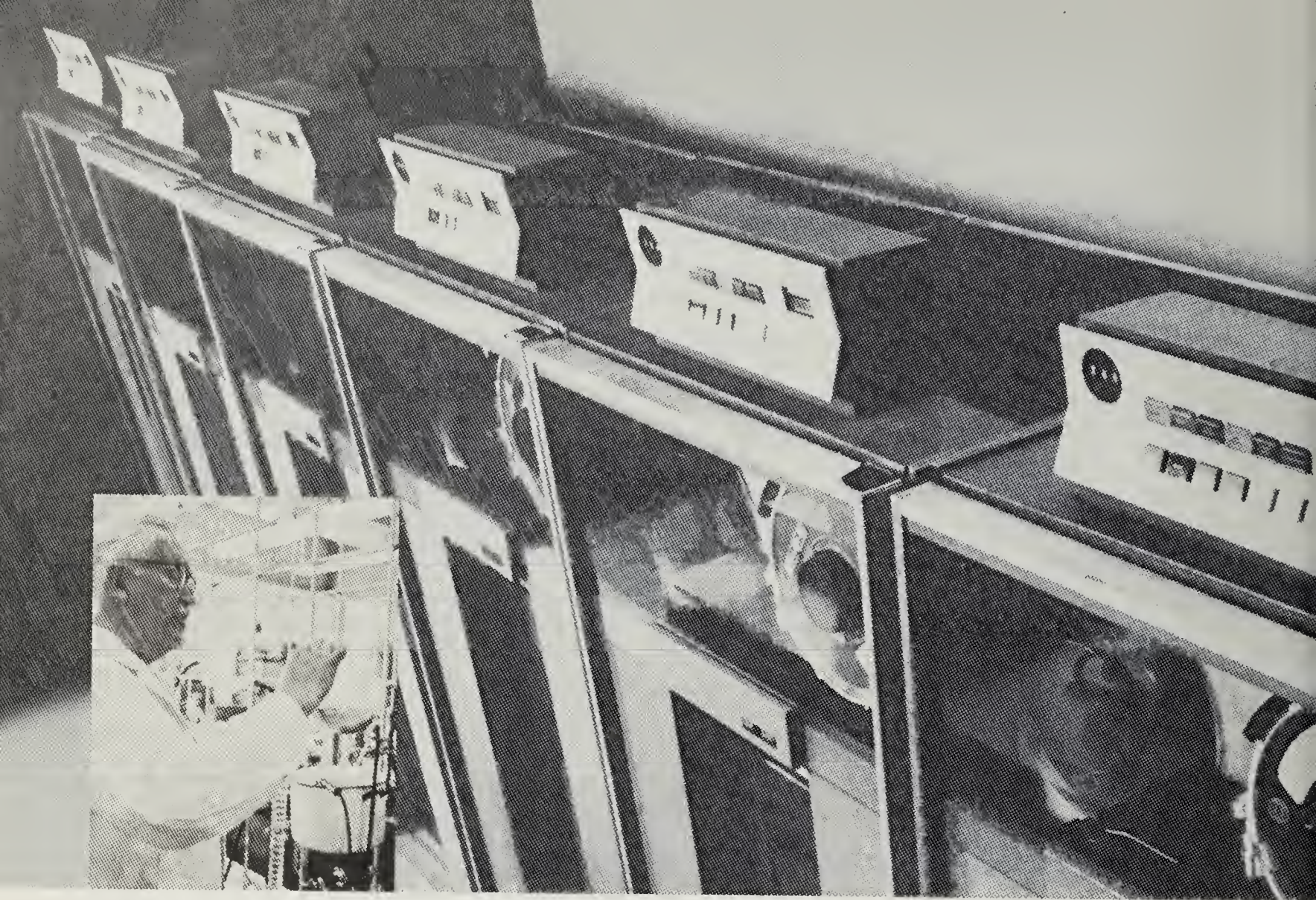
Do panels work?

Defense lawyers and insurers are beginning to have doubts. In Pennsylvania, panels have held hearings in only 14 of nearly 3,000 cases submitted to them since their creation four years ago. In light of huge backlog, state Supreme Court has agreed to hear case asking whether plaintiffs' due process rights are being abridged.

Florida Supreme Court heard arguments in January on that state's medical boards' constitutionality. Since 1976, 72 lower court opinions in Florida have questioned validity, operation of screening system. Claimants' costs for panel preparation and payment of panel members have ranged from \$10,000 to \$30,000.

In Maryland, 315 of 350 claims submitted to pretrial screening boards since July, 1976 are still open. Only 10 hearings have been held, and most claims proceed to trial regardless of panels' verdicts.

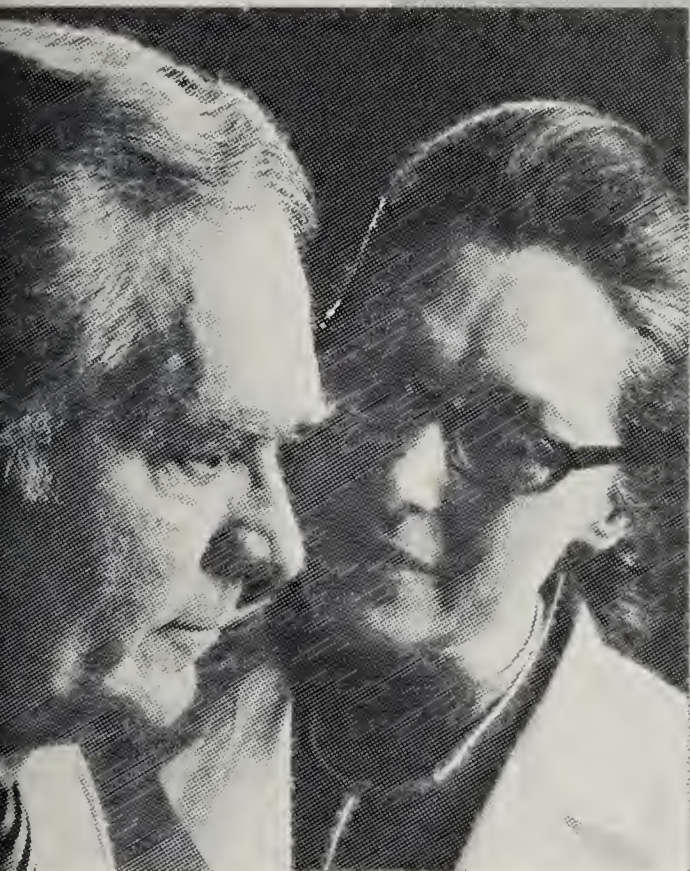
— from "Newsbriefs," Vol. III, No. 2, February, 1980, of the Michigan Bar Association.



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Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction, changes in EEG patterns (low-voltage fast activity) may appear during and after treatment, blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

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HEALTH PLANNING UPDATE

By Dennis Paradis, Director
MSMS Physician/HSA Support Center



HSAs use new regulatory tools

Appropriateness review

Health systems agencies (HSAs) can now perform two new kinds of reviews as part of their regulatory functions. HSAs will begin to review the "appropriateness of institutional health services" and make recommendations. These findings will be made public, and a plan for remedial action will be proposed when a service is determined to be "inappropriate." Services to be reviewed are: end stage renal disease, neonatal, obstetric, acute care medical/surgical, pediatric, long-term care and home health services. Appropriateness review is intended to critique existing services and facilities, while CON regulates the growth of new construction and service capacity.

Use of federal funds

Proposed Use of Federal Funds (PUFF) review is the authority given to HSAs to review and approve proposed uses of federal health project grant funds. The goal of the review program is to make federal funding of state health programs consistent with local health systems plan priorities. Examples of programs that will come under review are: health maintenance organization development, National Health Services Corps, mental health-hospital improvement grants, community health centers, substance abuse programs and emergency medical services.

Physician involvement up

According to a 1979 AMA survey, 31 state medical societies now have staff devoted to health planning. A similar survey taken in 1978 showed 18 state medical societies had staff dedicated to assist physicians in the health planning field. Michigan was a leader in this trend when the Physician/HSA Support Center was created pursuant to the 1978 House of Delegates Resolution 78A-53.

Michigan's medical schools appreciate physicians' contributions

Michigan's three medical schools have sent thank-you letters to MSMS headquarters for the recent annual contributions of the Michigan Foundation for Medical and Health Education.

The Foundation annually awards direct grants to the student aid committees of the state's medical schools for undergraduate medical education.

The Foundation, established by MSMS members in 1945, most recently awarded \$1,168.20 to the MSU medical school; \$2,633.40 to U-M Medical School, and \$2,798.40 to WSU. The funds are allocated on the basis of fall enrollment figures at the three medical schools.

"These funds are always put to

very good use as costs rise, and students are faced with ever-increasing tuition, book prices and living expenses," said W. Donald Weston, MD, dean, MSU College of Human Medicine. "You can be sure these students stipends are much appreciated by the recipients."

"We continue to have acute needs in the area of student assistance," said John A. Gronvall, MD, dean, U-M Medical School. "Our warmest thanks for your thoughtful provision."

And, said Robert D. Coye, MD, dean, WSU School of Medicine, "As you know, federal sponsorship of loan money has leveled off recently, and support from foundations like

yours is critically needed. Thank you for recognizing this special need, and helping us in such a fine way to do something about it."

The tax-exempt corporation accepts contributions at any time of year. (See ad below.) It also administers the James D. Bruce Fund, a bequest from one of the original board members which is used to support a graduate medical student at the U-M, and for the medical libraries of three Saginaw hospitals.

The Foundation board meets again May 14, when it will make its annual grants from income of the fund's investments.

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Contributions may be made at any time of year, and should be sent to Warren F. Tryloff, Foundation secretary, at the address below:

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Michigan's medical students: some statistics, some views



This issue's special report focuses on Michigan's medical school students today. We asked graduating students at The University of Michigan Medical School, Wayne State University School of Medicine, and Michigan State University College of Human Medicine to describe their views of the critical medical issues today and what they thought their roles should be when they become physicians. Their responses are published here.

Also included is a report from the assistant dean for student affairs at WSU School of Medicine, who describes medical school students today, and a statistical view of females in medical school today.

Total enrollment in the 125 US medical schools in 1978-79 was 62,754, an increase of 2,804 over the previous year, says the American Medical Association's 79th annual report on medical education, published in the March 7 *Journal of the American Medical Association*.

For the second successive year the AMA noted a significant downturn in the number of applicants to medical schools, said C. H. William Ruhe, MD, senior vice president for scientific affairs. The 1978-79 applicant total was 36,636, a drop of almost 4,000 from the previous year, and down from the peak year of 42,624 applicants in 1974-75.

There still were 2.2 applicants for each place in the freshman class. New enrollment totaled 16,620 students in 1978-79, an increase over the previous year's total of 16,134.

The medical schools graduated 14,966, a record number of new physicians at the close of the 1978-79 year, and an increase of four percent over the previous year.

The total number of women enrolled in medical schools continued to climb, to 15,293, an increase of 920 over 1977-78. Some 24.4 percent of medical students are women.

Ethnic minorities enrolled in medical schools in 1978-79 totaled 7,768, a percentage of 12.5.

Doctor Ruhe noted that "Again the trend at both the federal and state level is in the direction of increasing regulation of the medical education system, increasing dictation of the terms of medical education and the content of the curriculum, and increasing regulation of the nature and location of physician's practices."

At the federal level, he said, the movement of legislative support was away from medical education.

"In general, Congress is persuaded that the supply of physicians is now adequate and that financial support for schools of medicine may be reduced safely."

At the state level, there were efforts to restrict licensure of new physicians in two states, and other proposals to limit the numbers of new residency programs, as states feared an over-supply of doctors or a relative imbalance between primary care physicians and secondary/tertiary care physicians.

Competition for undergraduate grades can limit students' social consciousness

By Charles C. Vincent, MD, Detroit



The typical Wayne State University School of Medicine student today is a mature scholar, interested in science, its changes and challenges, motivated to help others, and knowledgeable about the financial and emotional rewards of a medical career.

While social conditions in Michigan may create some changes in the student body, the average Wayne State University medical student today still is white, male, at least second generation American, from a large suburban area and middle class family, who, while knowledgeable about poverty, malnutrition, social ills and disease, has had very little personal experience in these areas.

More scientific

Future physicians will be rendering a much more scientific form of medicine than the graduate of earlier years. Thus, in searching for students we try to maintain a high level of academic excellence while identifying evidence of the candidate's desire to help others.

At our medical school, recognizing both the tremendous need for a student body truly representative of Michigan's population, and the growing societal demand for correcting the inequitable geographic distribution of physicians, we have included economically disadvantaged white students and those applicants from medically underserved areas of our state for special consideration.

Doctor Vincent is associate dean of student affairs, Wayne State University School of Medicine.

As might be expected, the number of both minority students and those students given special consideration who are eventually accepted is decreasing. This is partially due to the decreased availability of financial assistance and the various reverse discrimination suits that the medical school has been confronted with.

The Health Professions Education Act of 1976 authorized almost \$3,000,000,000 for health manpower training, placing the cost of a medical school education within the reach of most students. Yet, financial assistance continues to be one of the major challenges in obtaining a medical education.

Fortunately, with the relatively low tuition costs of our state-supported medical schools (as compared to other medical schools¹), and a well-informed financial aid office, we are able to offer various funding programs to accommodate most students.

The selection of Wayne State University medical students is based essentially on six factors: 1) Grade point average, 2) Performance on the Medical College Aptitude Test (MCAT), 3) Letters of recommendation from the undergraduate college, 4) Extracurricular activities, 5) The interview, and 6) Written responses to questions formulated by our Admissions Committee.

¹Michigan Medical Schools \$3,000/year tuition
Georgetown Medical School \$14,750/year tuition
Washington University Medical School \$12,500/year tuition

Currently our medical students have a mean undergraduate grade point average of 3.56. To maintain such an average it is obvious that these students do not see very many grades other than A's, and the presence of three or four C's on a transcript essentially eliminates one from consideration for entry into our medical school.

Personally, I think this competitive undergraduate environment tends to limit exposure of pre-medical students to the areas which aid in developing social consciousness. Students need experiences which help them understand the dynamics of human relationships which are so important to become a "good doctor."

Attributes lost

Extracurricular activities do play a role in selecting medical students, but they do not carry the degree of importance I personally would like to see. Many of the attributes I feel a physician must have the time to develop are lost while students are earning the top grades required for entry.

While medical school applicants are decreasing across the United States, the actual number of Michigan in-state applicants has not substantially changed. In fact, there has been a continual increase in both overall grade point average and MCAT performance level. Of equal interest is the increase in female and black applicants during these same

(continued on page 244)

Physicians' role to cure and care — importance of latter must not be overlooked

By Robert Pacer, Detroit



There are several critical issues in the field of health care delivery today deserving the attention of the practicing physician.

One issue is the dire need for a national health insurance plan. Many physicians are probably very tired of discussing this issue. Yet with all the attention given to this topic there is still no solution. Thousands of Americans are still without adequate health care.

Comprehensive insurance

Personally, I would support a legislative proposal advocating federally-mandated comprehensive insurance coverage of normal and catastrophic illness for all citizens. Support for such an insurance plan needs to come from every practicing physician. I was disappointed at the AMA's recent decision to introduce such a bill into Congress "only if necessary." It seems apparent that it is in fact "necessary" and has been for quite some time now.

Directly related to the issue above is that of physician maldistribution. Assuming that legislation is enacted for national health insurance, thereby solving the problem of availability of health care, the issue of accessibility of health care requires attention.

This is being partially addressed with the establishment of the National Health Service Corps. How-

ever, the NHSC is not without problems, including scholarship recipients who have chosen to "buy out" of their commitment and those who serve their obligations and then leave the underserved area. Perhaps some of these problems could be solved by recruiting students whose personal goals and philosophies parallel those of the Corps. It may be necessary to go one step further and seek out medical school applicants who have a vested interest in practicing in a physician shortage area.

The third issue deserving emphasis is the important role of the primary care physician in our fragmented health care system. The primary care physician is absolutely essential in maintaining an overview of the patient's total health care picture. Too frequently the patient is approached from the limited expertise of individual subspecialists leaving too much room for oversights to occur. In addition, the "doctor-patient relationship" strengthens when the patient has a physician who serves as a "home base." Strengthening this relationship leads to greater compliance and patient interest in health care.

Fourth, a growing trend may be seen toward the use of physician extenders within the health care delivery system, including physicians' assistants, nurse practitioners and social workers. The role that these individuals play in the health care team will broaden as the physician's responsibilities and other time restraints limit his or her time devoted to patient care. The key word above is "team" of which the physician is

the foundation. Each member of the team needs to be dedicated to quality health care with the physician directing these efforts and seeing that this goal is achieved.

A fifth issue is the growing emphasis on patient education and preventative medicine. Having spent two months in a general practitioner's office in a suburb of Detroit, I was pleased to find a significant degree of patient interest in the disease process.

Patient seminars

Being personally interested in general internal medicine, I have given considerable thought to the possibility of coordinating a series of patient seminars covering common diseases. Although time restraints may prohibit direct participation in such activities, this is where the services of other members of the health care team can be recruited. The physician should be responsible for the promotion of patient education, thereby establishing a base for preventative medicine.

Finally, I would like to discuss the roles of the physician in a general sense. Very simply, the physician serves two major roles — one of curing and one of caring. It is estimated that 75 percent of the patients who visit the physician's office have a problem which can be solved by the caring function alone. Although this seems like a simple task, all too often I have seen it overlooked during my two years of clinical clerkships. Therefore, I find it worth mentioning that the importance of the caring role must not be minimized.

Mr. Pacer is president of the Wayne State University School of Medicine class of 1980.

Public's dissatisfaction with medical care a mandate to new and established MDs

By Michael H. Zaroukian, MD, East Lansing



As one of Michigan's newest physicians I have been asked to share my thoughts regarding medical practice. This article will provide for practicing physicians in Michigan the graduating medical student's perspective of the major issues in medicine today and in the future.

Throughout medical school, students encounter directions and decisions in medicine which influence personal career choices and philosophies of patient care. Our country manifests a need for providers who can simultaneously manage such basic and low cost primary medical care as nutrition education and immunization and deliver highly sophisticated and expensive care, such as critical care and transplantation medicine. Students must make important decisions as to how their careers will fulfill these societal needs, while also meeting their personal needs.

Students concerned

Like practicing physicians, students are concerned about the escalating cost of medical care and along with most of our patients are relatively uninformed as to the cost of each increment of care.

Similarly, new and practicing physicians often are incompletely cognizant of the seemingly innumerable diagnostic and therapeutic devices and the cost-benefit ratios of their use. As medical students and

residents, we realize that we are an additionally significant, though necessary, part of the cost of medical care.

Many of us are concerned with and would like to see changes in the current system, which provides more financial incentives to performing multiple procedures or laboratory tests than it does for a thoughtful and thorough history and physical examination, patient education, and personalized patient care.

Some of our patients also contribute to this problem, insisting that we "do something," such as obtaining a laboratory test, prescribing a medication or even performing an invasive procedure and thereby rewarding "doing" rather than thinking.

These and related issues have resulted in the movement toward a national health insurance, a discussion of which is beyond the scope of this commentary. It is sufficient to note that such a movement represents dissatisfaction with the current health care system. This dissatisfaction requires the concerted efforts of new and established physicians working at local, regional and national levels to provide optimal care for all, with minimal waste of one of our nation's most valued resources, the productivity that comes with continuing physical and mental health.

As new physicians, we realize that an enormous increase in national health could be gained if we could only persuade our patients to exercise regularly, eat three balanced meals each day with minimal snacking, achieve and maintain an ideal body weight, minimize or eliminate alcohol intake, stop smoking, wear

seatbelts, obtain seven to eight hours of sleep each night and adjust their personal and professional lives to minimize chronic stress. We frequently encourage patients to adopt these life habits, with variable success.

If patients look to the medical profession to set an example in this regard, they need only to look at the traditional residency training program to see that one does not always practice what one preaches.

The typical resident may sleep infrequently and fitfully, eat nutritionally poor meals, exercise irregularly if at all and work under stress with inadequate time for spouse and family.

It is difficult to believe that such an imposed lifestyle is necessary to produce a competent and compassionate clinician. Indeed, the latter trait may be diminished by such a life experience, however transient.

Better lifestyles

It seems likely we would reduce the incidence of maladies that affect physicians with greater than average frequency, such as divorce, alcoholism, drug abuse and suicide, if we were to adopt the lifestyles that we recommend to our patients.

Above all, we need leadership and cooperation in medicine: leadership to guide the continuing changes inherent in an area where knowledge increases geometrically over time, and cooperation to best combine our knowledge and experience to the best service of our patients.

We look to practicing physicians for guidance. We could not be in better hands.

Doctor Zaroukian is a member of the 1980 senior class, Michigan State University College of Human Medicine.

Physicians' role in the future needs to be clarified, refined

By Michael W. Klinkner, Ann Arbor



Any article concerning one's opinions on directions and issues in health care will be affected by one's background and selected field. Thus, I think a brief comment on these topics might be helpful.

I come from a non-medical family, and I'm sure my ideas are based on my family's dealings with the present health care system. Also, I am going to Kalamazoo this summer to start a family practice residency program, so my slant is decidedly toward primary care.

My personal goals include becoming a very competent family physician, and helping to define the role of primary care among the specialties.

Primary care pivotal

It should be no surprise, then, that when I look to the future I see primary care specialists having a pivotal position in health care delivery. They will be the patients' first contact, primary diagnostician and therapist, medical educator, and health care coordinator when other specialists or services are required.

Such a system with family practice pivotal, hopefully will be efficient, cost effective, and satisfying to the patient, in contrast to the sometimes disorganized way things often are done now. Physicians, too, should be satisfied in their roles, practicing the types of medicine they choose.

I see patient education as a must for the future as individuals assume

greater responsibility for their own health and disease prevention. It's encouraging to see steps being taken in these directions already.

The issues of the future will have familiar sounds — national health insurance, questions as to who will make ethical decisions, and how best to serve physician shortage areas.

A troublesome item rearing its head even now is who (meaning how wealthy they must be) will make up future medical school classes. As costs rise and funds dry up, qualified students may select other less expensive areas of training or face the prospect of being obliged to a funds-for-service plan.

Medical classes already are filling with more well-to-do people, and some schools use ability to pay as an admission criterion.

This doesn't sound like a healthy situation to me at all, not that more economically secure people are unworthy, but that a large segment of our population will go unrepresented in medicine. I don't have any answers, but we must start thinking now.

As far as national health insurance is concerned, I'm sure everyone wishes adequate health care for all, especially in a wealthy, free society like ours. But as long as people are smart enough to see the relative efficiency of federal government institutions, they'll be smart enough to keep health care out of the hands of those who run the post office.

I don't think the role of physicians will change that much in the future, but I hope it will be more refined. Physicians still must be the

chief decision maker and leader of the health care team. Other people involved in care — nurses, PA's, social workers — can be used to great advantage, but the physician still must lead. Roles must be clearly defined, so that primary care specialists practice primary care, and orthopedists practice their craft, all functioning in a well-running system.

Patient education needed

One big deficit I hope to see filled is patient education. I know physicians are pressed for time, but there would be less so, not more, if they took a little more time to teach patients about themselves, their health and their treatment. The medical educator role is quite necessary for the physician to take.

Physicians today really amaze me. For all the incredible advances in medicine over the past few decades, physicians have kept up with current practice very well. I look forward to sharing in that educational system that keeps physicians up to date.

However, I see today's physician as somewhat under siege, being more accountable by society for their actions and income. These are probably healthy developments, for they cause us to self-evaluate and change if necessary. Also, there is some confusion as to what the physician's duties are among all the paramedical personnel, but this should be clarified as more thought goes into role definition.

And finally, I still think medicine is the finest profession on earth and am very thankful that I have the opportunity to participate in it.

Mr. Klinkner is president, Medical Student Council, University of Michigan Medical School.

Latest information from Michigan's three medical schools reveals they are close to admitting the same percentage of women as men who apply.

Wayne, U-M, MSU

The Office of Admissions at Wayne State's School of Medicine reports the number of women enrolled has grown to 223 of a total 706 in 1980. This is up from 1976 when only 167 females were part of the student body. The Wayne student body included 186 women in 1977; 188 the following year; and 208 in 1979.

The Dean's office at University of Michigan Medical School says current female enrollment is 283. This total includes women enrolled in their integrated medical-premedical program and the standard curriculum, and amounts to about 30 percent of their entire enrollment of 965.

Comparable figures from recent years indicate the number of women students at the U-M has grown slightly. In 1977 there were 248; in 1978 the number was 253; in 1979 it was 277. U-M expects the percentage of women to stay about where it is unless there is a substantial increase in the number of female applicants.

The College of Human Medicine at Michigan State University reports a steady increase in the number of women enrolled since 1973.

At present 45 percent of the 19-member student body is female. This is up from 35 percent in 1978 and higher than any year since 1974, when the student body was comprised of 40 percent female and 60 percent male.

All Michigan medical institutions stress they have a pattern of accepting at least the same percentage of female applicants as male. This is not so much a planned phenomenon, indicates John B. Molidor, PhD, assistant dean at MSU, as a natural result of admission procedures. MSU measures applicants for traits which match goals of its college, he says,

(Continued on page 244)

Females close to 30 percent of Michigan med student numbers

By Elmer White, special to Michigan Medicine



One in three Michigan medical students today is a woman.

Female physicians still earn less

Although there is much now to indicate that women have attained equal status at the medical school level, there still is much to indicate they have not reached equal earnings status in the professional world.

A *Wall Street Journal* review of a *Medical Economics* survey shows women doctors in private practice had a median income, after expenses, of \$39,820 in 1978. This compared with \$67,450 for males.

The 41 percent gap, which has existed since 1974, had been expected to narrow by the 1978 survey.

Reasons for the difference, conjectured the financial newspaper, might lie in women's preferences for lower-paying specialties like pediatrics and psychiatry.

The *Medical Economics* survey, which covered 18,000 physicians, found that women doctors tended to see about 40 fewer patients per week than did male counterparts. This difference alone makes a variation of \$33,000 per year. The *Journal* also suggested that female physicians, faced with family responsibilities, choose to devote less time to their profession.

SPECIAL REPORT/continued

and approximately the same proportion of women are qualified as men.

Once in the training, sex seems to be about the only means of identifying students. In other words, says Jane S. Schultz, PhD, of the U-M, women and men students seem to fall into the same patterns. Similar percentages of each group make similar decisions about careers, have similar problems and establish similar records.

"Women come into our program as equals," says MSU's Doctor Molidar, "and they feel it. They convey this feeling to others and there is little problem."

Michigan medical schools seem to be somewhat ahead of the national trend.

The American Medical Association reported in March, 1980, that the

total number of women enrolled in the nation's 125 medical schools equals 15,293, an increase of 920 over last year. Nationally women make up about 24.4 percent of all medical students.

Growing to 13 percent

AMA Center for Health Services Research and Development estimates about nine percent of today's practicing physicians are female and predicts that this number will grow to 13 percent by 2000.

An examination of MSMS records shows that 635 of the organization's 9,610 members are women.

The Michigan Cooperative Health Information System lists women medical doctors and doctors of osteopathy in January of 1973, 1976 and 1978, although it indicates that data in the two earlier time periods might not be complete.

Records in that office show that in 1978 there were 1,118 female MD among a total of 11,768 physicians in the state. This amounts to 9.5 percent.

This was up from 1976 when 63 females were listed of a group of 8,402, or 5.7 percent. In 1973, the office listed 499 woman MDs in a total of 9,915, some 5 percent of the total.

Osteopathic physicians included 92 women in 1978, which amounts to 4 percent of 2,305 listed.

This represents an increase from 2.4 percent in 1976 when 49 women were identified from a total of 2,051 practicing osteopaths.

MSMS female members include 98 specialists in internal medicine and 92 in pediatrics. The next most preferred specialty is obstetrics/gynecology which shows 70 women doctors. Numbers of female physicians in other specialties include general practice, 65; physical medical and rehabilitation, 43; anesthesiology, 42; pathology, 34; radiology, 19; ophthalmology, 12; and neurology 12.

These changes show progress from 1975 when an article in *Michigan Medicine* reported that women medical students made up 20 percent of the total enrolled in first-year classes. At that time WSU listed 1 percent of its students as female and U-M said that 39 percent of its freshmen class, and 24 percent of the total enrollment, was made up of women. (MSU had no four-year figures; it was not fully functioning as a four year school then.)

It is apparent that since the impact of the feminist movement and the enforcement of anti-feminist law that medical schools have moved clearly and rapidly to meet numerical goals.

Although there might still be problems with peer group pressure or emotional strains among women students, they do not seem to be problems of magnitude.

The future will tell us of the success of recent changes in the medical profession designed to equalize opportunity for medical training between the sexes. At present, all indications suggest that chances for full effectiveness are bright.

DOCTOR VINCENT/continued

years. For example, in 1972 there were 15,283 female applicants and in 1978, 19,143. During those same years the number of black applicants increased from a level in 1972 of 4,225 to 4,959 in 1978.

While there have been many changes in the medical school curriculum over the years, the students' overall level of performance on the various national board and other qualifying examinations has remained essentially the same. I have noted little change with regards to humanitarian concerns demonstrated by students over the years. I think the students with whom I had contact during the rebellious Sixties perhaps (actively) pursued more community involvement, but a part of that might have been simply a manifestation of the overall societal conflict during that period.

Primary care

Of our 1980 graduates, 20 plan a career in family medicine. With other disciplines now included under the umbrella of "primary care" (internal medicine, pediatrics, emergency medicine and ob/gyn), we find 50 percent of our 1980 graduates planning to pursue such careers. It is also interesting to note that a larger percentage of our graduates plan to practice in small communities and most

within Michigan. This is probably true because in the majority of cases we only give Michigan residents serious consideration for entry to our medical school.

The years spent in medical school have changed little. The psychological stresses, the "can I make it . . . is it worth it" attitudes, continue to occupy many students' thoughts. From the large number of academically excellent students we admit, it would be expected that our attrition rate would be relatively low. Fortunately, this is the case. At Wayne State University, with one of the largest medical school enrollments on a single campus in the United States (256 per class), our attrition averages less than 3 percent. Most of those students are lost during the first two years of basic sciences.

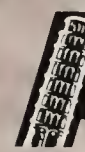
Thanks to the Michigan State Legislature's funding of our medical school's Gordon H. Scott Hall of Basic Medical Sciences, the enormous growth of the Detroit Medical Center and its affiliated institutions, and the clinical advantages offered by a location within the City of Detroit, the training of such a large student body is practical and among the best available anywhere. This is a tremendously challenging group of young people to work with — an experience I treasure.

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avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE**

REACTIONS: Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. **In the male:** Eunuchoidism and eunuchism, 10 to 40 mg. Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg. Postpuberal cryptorchism, 30 mg. **REFERENCE:** R. B. Greenblatt, M.D.; R. Witherington, M.D.; I. B. Sipahoglu, M.D.: Hormones for Improved Sexuality in the Male and the Female Climacteric. *Drug Therapy*, Sept. 1976. **SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only.

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Here are details, impact on MDs of new Blues reimbursement system

By John A. Richards, chief, MSMS Bureau of Economics

In early April, Blue Cross Blue Shield of Michigan put its new reimbursement system into effect.

MSMS has closely monitored the development of the system during the past two years, and has been aware of the Blues' discussions proposing these changes.

Following is a brief MSMS analysis of the major features of the new BCBSM system:

Regional committees.

Ten regional committees will be formed with consumer majorities. Each committee will have representatives of subscriber groups, "consumers" and physicians (two MDs and one DO). The purpose of the committees will be to receive data produced by BCBSM on utilization patterns within the region and to identify individuals and groups overusing the system. The committee will then attempt to change these utilization patterns by educating the people involved. If this effort fails, the committee may recommend to the

BCBSM Board the physicians or groups which should not be allowed to participate in their programs.

Maximum screen determination.

The maximum screens for individual procedures will be determined by calculating a figure which will pay 85 percent of the aggregate charged in the previous year's billings. Previously, the screen was established by determining that amount which would pay in full 85 percent of the number of charges for a procedure. The screen will be updated automatically each year. The update will not be applied uniformly to each of the geographic regions. Those regions having an average per member expenditure equal to or lower than the state average will receive the full screen update. Those regions which are above the state average will receive no increase in the screens.

Service incentive program.

Incentives to provide certain services in the most cost effective loca-

tions will be developed. The procedures qualifying for these incentive will be identified by BCBSM. It is presumed these incentives will include increases in the amount paid for the procedure when it is performed in certain locations.

Automatic customary profile adjustments.

Profiles will be adjusted automatically annually using a limitation formula developed by BCBSM. Each physician will receive a aggregate increase equalling the percentage increase allowed under this formula. These percentages will not be applied equally to each procedure but will be calculated to narrow the physician's charges for an individual procedure toward the average charge for that procedure made by all physicians. This means for those procedures for which a physician is charging more than the average, he will receive less than the allowable percentage, and for those services for which he is charging less than the average, he will receive more than the allowable increase.

Laboratory reimbursement changes.

1. A fee schedule has been developed to pay 21 blood chemistry tests whether these tests are performed on automatic equipment or manually, eliminating the individual screens for these tests.

2. The blood handling charge screen will be reduced from the present \$5 to \$2.50.

3. All other screens for laboratory procedures will be established by BCBSM.

4. Payment for 47 procedures which have been reviewed by MSMS the Michigan Society of Pathologists and other organizations, will be eliminated as obsolete.

5. All independent labs will be required to sign participation agreements with BCBSM.

MSMS concerns with new Blues plan

MSMS has several concerns regarding these changes.

The first is the discontinuance of a single statewide screen.

After a number of years of concerns regarding discriminatory reimbursement policies, BCBSM last year instituted a single screen.

This new program could possibly produce a different screen in each of the 10 regions. No information is available on what the company plans to do in the second and third years of the program. Presently four regions will not receive screen updates for 1980. If these regions drop below the statewide average subscriber payout in 1981, it is not clear if they will receive only the updates for 1981 or the cumulative increase for 1980 and 1981.

The second major concern of MSMS is the regional committees.

These committees are being asked to determine appropriate utilization patterns based on data supplied by BCBSM. The physician minority on these bodies will be placed in the position of defending the practice patterns of physicians they may not know.

The data from BCBSM must be carefully studied and its quality must be verified. Many factors can influence utilization of medical services and the committees must have access to as much information as possible in order to understand the complex interrelationships of the different factors.



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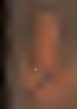
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INDICATION: For relief of constipation.

PATIENT WARNING: Should not be used in the presence of undiagnosed abdominal pain. Frequent or prolonged use without the direction of a physician is not recommended. Such use may lead to laxative dependence.

DIRECTIONS FOR USE—ADULTS: Before breakfast and after the evening meal, one to two rounded teaspoonfuls of Perdiem™ granules should be placed in the mouth and swallowed with a full glass of warm or cold beverage. Perdiem™ granules should not be chewed. After Perdiem™ takes effect (usually after 24 hours, but possibly not before 36-48 hours), reduce the morning and evening doses to one rounded teaspoonful. Subsequent doses should be adjusted after adequate laxation is obtained.

IN OBSTINATE CASES: Perdiem™ may be taken more frequently, up to two rounded teaspoonfuls every six hours.

FOR PATIENTS HABITUATED TO STRONG PURGATIVES: Two rounded teaspoonfuls of Perdiem™ in the morning and evening may be required along with half the usual dose of the purgative being used. The purgative should be discontinued as soon as possible and the dosage of Perdiem™ granules reduced when and if bowel tone shows lessened laxative dependence.

FOR COLOSTOMY PATIENTS: To ensure formed stools, give one to two rounded teaspoonfuls of Perdiem™ in the evening with warm liquid.

DURING PREGNANCY: Give one to two rounded teaspoonfuls each evening.

FOR CLINICAL REGULATION: For patients confined to bed, for those of inactive habits, and in the presence of cardiovascular disease where straining must be avoided, one rounded teaspoonful of Perdiem™ taken once or twice daily will provide regular bowel habits. Take with a full glass of water or beverage.

FOR CHILDREN: From age 7—11 years, give one rounded teaspoonful one to two times daily. From age 12 and older, give adult dosage.

NOTE: It is extremely important that Perdiem™ should be taken with a plentiful supply of liquid.

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PEER REVIEW EXCHANGE

PSRO — does it affect me?

By Daniel J. Fall, MD

We all have been involved recently in cost containment activities and bed reduction plans. These are the current hot issues in the economics of health care delivery — the areas in which we physicians are being asked to improve the supply and demand balance and the pricing of medical care systems.

Professional Standards Review Organizations (PSRO) have the potential to direct the demand for health care resources. If physicians, through their local PSROs, demonstrate that only physicians can and should decide the medical necessity, appropriateness, and quality of medical care, a by-product of this sensible and equitable approach could be a more cost-effective system. Further, it would seem highly unlikely that an arbitrary system of quotas could ever be legislatively endorsed.

The key is your involvement in your local PSRO. On a statewide level, the Michigan Statewide Professional Standards Review Council is operating to support, protect, and coordinate the efforts of all 10 local PSROs. We hope, through this new regular column, to give each of you

Doctor Fall is MSMS delegate to and president of the Statewide Professional Standards Review Council.

an opportunity through your PSRO to share your successes, concerns, and ideas about how you can and did affect not only peer review, but also utilization.

I have been involved in PSROs since the beginning. During the fall of 1972 a group of physicians, hospital administrators and other interested parties met together to discuss the impact of PL92-603, the federal legislation which gave birth to PSROs.

Concurrently, a committee of the Michigan State Medical Society was forming to address this same issue. I attended those first meetings in Ann Arbor. I later worked with the MSMS Committee trying to assure that our concerns as physicians were at the very least considered, but hopefully, formed the foundation for this peer review program.

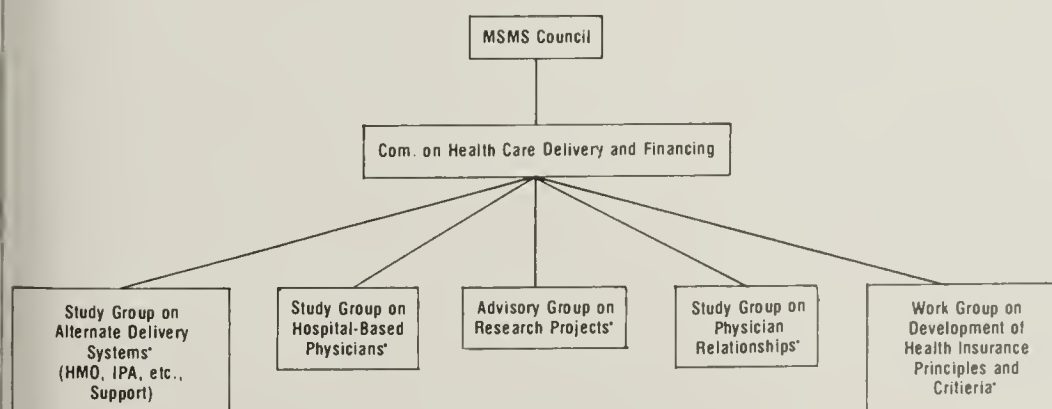
The Committee met in Washington, DC with PSRO/HEW staff; met with and sought support and

involvement of the county medical societies in the formulation of area PSROs; and testified at public hearings. We affirmed the concept that only physicians could monitor the quality of care delivered by physicians; and secondarily, that good quality care was cost-effective. Politicians supported this concept with the belief that "doctors would never do this" and "doctors were not interested in quality care." Their backward reasoning suggested that if the government let the doctors do it first, when the doctors fell through, the government could step in and take over.

Physicians are the managers of patient care, not hospitals, nor third party payors, nor government. PSROs are groups of local physicians serving as your advocates and advocates of your patients. If you wish to have a voice in the appropriate supply of health care resources, one way is through your PSRO.

Newly-organized MSMS Bureau to develop HMO/IPA support center

PROPOSED REORGANIZATION OF THE BUREAU OF ECONOMICS



* Progress Reports and Minutes to Advisory Committee.
Recommendations in Special Reports directly to The Council.

The MSMS Council has authorized the reorganization of the MSMS Bureau of Economics. The new structure will emphasize meeting the needs of physicians involved in the health care delivery system.

As increasing numbers of physicians are salaried, or heavily involved in prepaid plans or various other activities outside the traditional third party reimbursement system, MSMS hopes to develop principles to deal with these changes.

Additionally, the Bureau will continue its activities regarding Blue Cross Blue Shield of Michigan, research and data analysis activities.

(continued on page 252)

BUREAU OF ECONOMICS/continued

A single major committee has been appointed and charged with maintaining a broad philosophical overview of the total health care delivery system. This committee will not deal with specific issues, but will identify and set priorities for the issues affecting the delivery system. The committee then will appoint task forces to develop positions on these issues or plans of action to be carried out by the staff.

Jay K. Harness, MD, chairman of the Advisory Committee to the Bureau says, "The committee is charged with the responsibility of being an important pro-active and futuristic element of MSMS . . . in carefully understanding how health care currently is financed and making specific recommendations for future financing mechanisms. This assignment should include a thorough understanding of traditional insurance companies and the emerging prepaid health plans.

"Finally, the committee in its futuristic role should deal with other related issues affecting the economics of health care. Such an example could be a study of employed physicians, their increasing numbers and their circumstances."

As one of its first activities, the Bureau has been directed to begin development of an HMO/IPA Support Center. Presently there are at least nine groups of physicians in Michigan either studying or actively developing IPAs. It is hoped MSMS can provide information to these doctors as their plans progress. In order to assist physicians interested in prepaid plans, MSMS plans to sponsor a seminar in early summer on the fundamentals and issues of developing HMO/IPAs.

Another example of the type of work the Bureau will be pursuing is its involvement with the Michigan Health Data Corporation's Hospital Performance Measures Project. Briefly, the Hospital Performance Measures Project is a systematic comparison of hospitals clustered by patient population. This study has taken two years to develop and the first data is presently being presented to hospital leadership. The data derived from this project potentially will affect large sections of the health care system. The Bureau will continue to analyze it and present it to the committee for discussion.

The committee is charged with understanding and leading development of policies regarding issues like these and the changes in the BCBSM reimbursement system described in a separate article.

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Use in Lower Respiratory Disease: Antihistamines should **NOT** be used to treat lower respiratory tract symptoms including asthma

Antihistamines are also contraindicated in the following conditions: hypersensitivity to azatadine maleate and other antihistamines of similar chemical structure, monoamine oxidase inhibitor therapy (See DRUG INTERACTIONS Section).

WARNINGS Antihistamines should be used with considerable caution in patients with: narrow angle glaucoma, stenosing peptic ulcer, pyloroduodenal obstruction; symptomatic prostatic hypertrophy; bladder neck obstruction.

Use in Children. In infants and children especially, antihistamines in overdosage may cause hallucinations, convulsions, or death.

As in adults, antihistamines may diminish mental alertness in children. In the young child, particularly, they may produce excitation

OPTIMINE TABLETS ARE NOT INTENDED FOR USE IN CHILDREN UNDER 12 YEARS OF AGE.

Use in Pregnancy Experience with this drug in pregnant women is inadequate to determine whether there exists a potential for harm to the developing fetus.

Use with CNS Depressants. Azatadine maleate has additive effects with alcohol and other CNS depressants (hypnotics, sedatives, tranquilizers, etc.)

Use in Activities Requiring Mental Alertness: Patients should be warned about engaging in activities requiring mental alertness, such as driving a car or operating appliances, machinery, etc.

Use in the Elderly (approximately 60 years or older): Antihistamines are more likely to cause dizziness, sedation, and hypotension in elderly patients.

PRECAUTIONS Azatadine maleate has an atropine-like action and, therefore, should be used with caution in patients with a history of bronchial asthma, increased intraocular pressure, hyperthyroidism, cardiovascular disease, hypertension

DRUG INTERACTIONS MAO inhibitors prolong and intensify the anticholinergic (drying) effects of antihistamines.

ADVERSE REACTIONS The most frequent adverse reactions are underlined

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Cardiovascular System: Hypotension, headache, palpitations, tachycardia, extrasystoles.

Hematologic System: Hemolytic anemia, thrombocytopenia, agranulocytosis

Nervous System: Sedation, sleepiness, dizziness, disturbed coordination, fatigue, confusion, restlessness, excitation, nervousness, tremor, irritability, insomnia, euphoria, paresthesias, blurred vision, diplopia, vertigo, tinnitus, acute labyrinthitis, hysteria, neuritis, convulsions.

Gastrointestinal System: Epigastric distress, anorexia, nausea, vomiting, diarrhea, constipation.

Genitourinary System: Urinary frequency, difficult urination, urinary retention, early menses

Respiratory System: Thickening of bronchial secretions, tightness of chest and wheezing, nasal stuffiness

OVERDOSAGE Antihistamine overdosage reactions may vary from central nervous system depression to stimulation. Stimulation is particularly likely in children. Atropine-like signs and symptoms (dry mouth; fixed, dilated pupils; flushing; and gastrointestinal symptoms) may also occur

If vomiting has not occurred spontaneously, the patient should be induced to vomit. This is best done by having him drink a glass of water or milk after which he should be made to gag. Precautions against aspiration must be taken, especially in infants and children

If vomiting is unsuccessful, gastric lavage is indicated within three hours after ingestion and even later if large amounts of milk or cream were given beforehand. Isotonic and ½ isotonic saline is the lavage solution of choice.

Saline cathartics, such as milk of magnesia, draw water into the bowel by osmosis and therefore are valuable for their action in rapid dilution of bowel content.

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Report from Maternal Health Conference

Pregnant teens have special needs

By Judith Marr, editor

There were 354 Michigan girls between the ages of 11 and 14 who gave birth in 1978.

That same year, 7,599 girls between the ages of 15 and 17 gave birth, and 13,818 aged 18 and 19. For some, it was their second or third pregnancy.

"And these are only the girls, not the boys, involved," emphasized Darlene T. Hinkle, BSN, MS, administrator for the Improved Pregnancy Outcome Program of the Michigan Department of Public Health and the Michigan Division of Maternal and Infant Health.

Ms. Hinkle was one of the speakers for the 1980 Michigan Conference on Maternal and Perinatal Health. Adolescent pregnancies was one of the major topics. Also discussed at the two-day session at the Hyatt Regency Dearborn were new techniques for monitoring and evaluating the fetus and newborn, bonding and breast feeding, viral and bacterial infections, anesthesia in births, use of drugs in pregnancy and rubella's effects.

Ms. Hinkle described the IPO program, which is designed to prevent adolescent pregnancies, or if they are already a fact, to improve their outcome. There are four IPO demonstration projects in the city of Pontiac and counties of Newaygo, Hillsdale and Genesee.

Create stress

Both Ms. Hinkle and Marilyn L. Poland, PhD, assistant professor of gynecology and obstetrics at Wayne State University, pointed out ways in which our current systems create problems for and do little to prevent adolescent pregnancies.

Doctor Hinkle reminded the audience, when considering the pregnant adolescent, to keep in mind a 15-year-old high school freshman

without transportation who is expected to be in school most of the day.

Clinic hours often are a barrier to good health care for the pregnant adolescent, she pointed out, as well as the clinic's location in a different ethnic area. Costs can be a barrier. If the pregnancy test is positive, the expectant mother may have a six-week wait before the referral appointment or may not get one at all.

Doctor Poland, who has studied the stresses of adolescents as possible sources of problems in their pregnancies, says "We (health professionals) may be the source of stress for adolescents in their care."

Physicians and nurses, for example, have very different beliefs in contraceptives, she said. Patients may think contraceptives cause cancer and "mess up their sex lives."

Afraid and confused

Adolescents are afraid and confused when they see several physicians, she continued. Continuous care by the same professionals is important to them.

The female adolescents in one of Doctor Poland's studies were 92 percent black, single, from the Detroit area, and under 17 years of age.

Most had known the father a long time. The quality of their relationship was more important to the mother and had more to do with her feelings about pregnancy than whether they were married or not.

"When we make statements that unwed mothers are at higher risk we may be doing a disservice," she said. It is not the married or unmarried state which necessarily makes problems.

Most of Dr. Poland's subjects were not trying to become pregnant, but most were proud of their pregnancy. Most were frightened about childbirth and felt labor would be painful and difficult. Girls who

thought doctors were helpful and not frightening were less afraid of childbirth. Most were concerned about their ability to care for a baby of their own.

Pregnant adolescents and adolescent parents have many personal, social, educational and health-related needs, said Doctor Poland. A comprehensive program focused on the adolescent's perception of her needs and problems and provided by a small team of professionals who see her continuously through pregnancy and post-delivery care could meet many of those needs.

Education needed

Another speaker was Jack M. Stack, MD, president of the Family Health Research Education and Service Institute of Alma.

Doctor Stack has studied how the pregnant adolescent decides whether or not to keep the baby, in an effort to help her weigh the advantages and disadvantages of the decision.

"These women should have supportive psychotherapeutic help throughout their pregnancy once they decide to keep their babies," he said. "And the family should be included in the counseling."

Doctor Stack cautioned health care professionals to be aware of ambivalence or coercion on the part of the family and father, and to ask if it is the pregnant woman's decision to keep or abort the developing fetus.

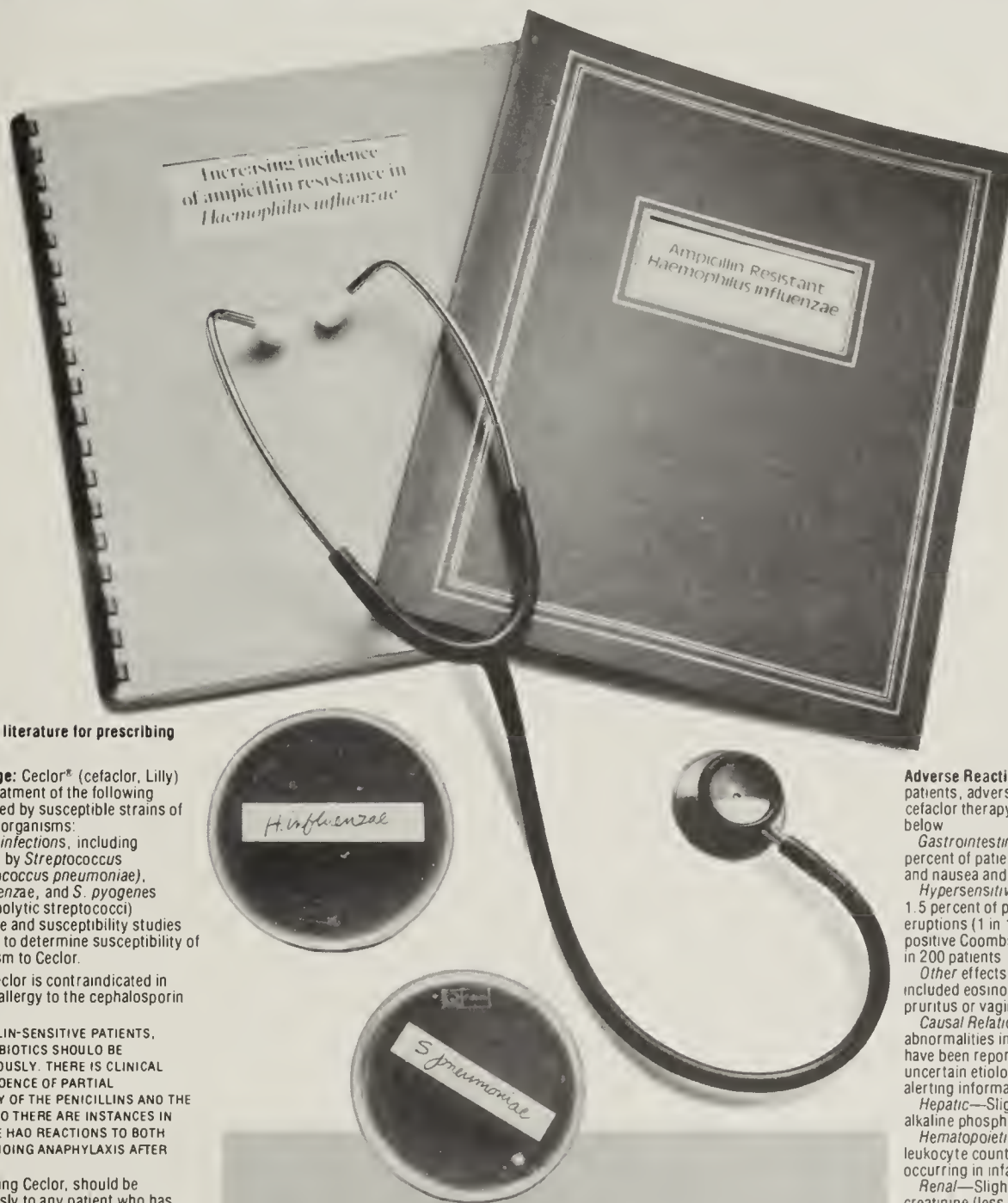
"Be aware of the nature of her support system," he said. "If she has none, she is in jeopardy of making a decision placing her in danger of future problems."

"If we determine she is isolated, we can and must mobilize additional resources and must extend our extra interest, discussion and support."

Both Doctor Hinkle and Doctor Stack called for better health education in the schools.

Photo highlights appear on pages 256-257.

An added complication... in the treatment of bacterial bronchitis*



Brief Summary. Consult the package literature for prescribing information.

Indications and Usage: Cefclor® (cefaclor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms:

Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae* (*Diplococcus pneumoniae*), *Haemophilus influenzae*, and *S. pyogenes* (group A beta-hemolytic streptococci)

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Cefclor.

Contraindication: Cefclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS, AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS TO BOTH DRUG CLASSES (INCLUDING ANAPHYLAXIS AFTER PARENTERAL USE).

Antibiotics, including Cefclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

Precautions: If an allergic reaction to cefaclor occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids.

Prolonged use of cefaclor may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs test may be due to the drug.

Cefclor should be administered with caution in the presence of markedly impaired renal function. Under such a condition, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

Usage in Pregnancy—Although no teratogenic or antifertility effects were seen in reproduction studies in mice and rats receiving up to 12 times the maximum human dose or in ferrets given three times the maximum human dose, the safety of this drug for use in human pregnancy has not been established. The benefits of the drug in pregnant women should be weighed against a possible risk to the fetus.

Usage in Infancy—Safety of this product for use in infants less than one month of age has not been established.

Some ampicillin-resistant strains of *Haemophilus influenzae*—a recognized complication of bacterial bronchitis*—are sensitive to treatment with Cefclor.¹⁻⁶

In clinical trials, patients with bacterial bronchitis due to susceptible strains of *Streptococcus pneumoniae*, *H. influenzae*, *S. pyogenes* (group A beta-hemolytic streptococci), or multiple organisms achieved a satisfactory clinical response with Cefclor.⁷

Cefclor®

cefaclor

Pulvules®, 250 and 500 mg

Adverse Reactions: In clinical studies in 1493 patients, adverse effects considered related to cefaclor therapy were uncommon and are listed below.

Gastrointestinal symptoms occurred in about 2.5 percent of patients and included diarrhea (1 in 70) and nausea and vomiting (1 in 90).

Hypersensitivity reactions were reported in about 1.5 percent of patients and included morbilliform eruptions (1 in 100). Pruritus, urticaria, and positive Coombs tests each occurred in less than 1 in 200 patients.

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

Causal Relationship Uncertain—Transient abnormalities in clinical laboratory tests results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician.

Hepatic—Slight elevations in SGOT, SGPT, or alkaline phosphatase values (1 in 40).

Hematopoietic—Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40).

Renal—Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200).

[070379R]

* Many authorities attribute acute infectious exacerbation of chronic bronchitis to either *S. pneumoniae* or *H. influenzae*.

Note: Cefclor® (cefaclor) is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

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8. Principles and Practice of Infectious Diseases (edited by G. L. Mandell, R. G. Douglas, Jr., and J. E. Bennett), p. 487. New York: John Wiley & Sons, 1979.

Lilly

Additional information available to the profession on request from Eli Lilly and Company, Indianapolis, Indiana 46285

Eli Lilly Industries, Inc. Carolina, Puerto Rico 00630

000482

Maternal Health Conference photo highlights



Sociocultural aspects of adolescent pregnancy – the topic of Marilyn L. Paland, PhD, above, drew many questions at the recent annual MSMS conference on Maternal and Perinatal Health. Doctor Paland's observations are described in the accompanying article.



From left, conference co-chairmen Bruce A. Wark Jr., MD, and John W. Hallitt, MD, smoothed out details with speakers Darlene T. Hinkle, BSN, MS, administrator, Improved Pregnancy Outcome Program, Michigan Department of Public Health and Michigan Division of Maternal and Infant Health, and with Doctor Paland.



There was a flurry of activity at the main conference doorway, as physicians and nurses received confirmation of attendance slips to earn continuing education credits. At left, Katie Brewbaker, MSMS staff coordinator for the conference, distributes attendance certificates.



The crowd seemed to go on and on — there were 1,100 physicians, nurses, students and others at the 1980 event.



More than a casual interest was displayed by Marilyn LaSovage, MD, left, and Karen Buck, RN, right, both of whom were expecting at the time of the conference.

**Photos by Mert Scholten,
MSMS staff**

Physicians, hospitals should join to provide patient education

By Craig L. Kippels, MBA and Frankie Perry, RN, AB, Flint



BILL TOLL, HURLEY MEDICAL CENTER

Proof of a relationship between patient education and both malpractice litigation and patient compliance needs to be demonstrated to physicians if they are to be motivated to negotiate with hospital administrators for the implementation of patient education programs.

Physicians remain the key decision makers within the health care industry. In the hospital they still enjoy the supreme position in the hierarchy. Physicians, though not generally employed by hospitals, establish and maintain the rules that regulate patient care.

Physicians key

Physicians are the hospital's "gate keepers" and patients must rely upon them to gain access to the health care system. Patients cannot be admitted to a hospital nor receive diagnostic and/or therapeutic services without physician's orders which define the role and behavior of patients and regulate their activities.

It is less obvious, but equally significant that these orders also de-

fine the role and behavior of hospital staff.

Since the physician alone determines how much and what kind of information a patient receives regarding care and treatment, the apprehensive patient who seeks an explanation of what is happening frequently may be told "You'll have to ask your doctor."

If patient education can be shown to increase patient compliance and decrease malpractice litigation, physicians not only will see its advantages, but will demand implementation of education programs for their patients. Hospitals and other health care organizations will be required to allocate resources to meet these physician demands.

Even though the physician must be the catalyst for patient education programs, hospitals cannot ignore their obligation to provide the best possible health care for the patient. The hospital also has a vested interest in reducing malpractice litigation. For these reasons it is both necessary and in the mutual interest of the hospital and the physician to form an alliance to generate and support patient education.

Physicians must provide the medical knowledge and expertise that is the basis for patient education programs. As the key decision makers they must act as the approving agents for these programs.

It is the physician who will prescribe patient education as part of the patient's treatment regime. The hospital acts as a resource center for the development of the programs that the physician sees as good and necessary for the patients.

In the development of patient education programs the hospital must provide consumer indicators for programs as well as audits which measure the effectiveness of these programs. Such mechanisms would include patient advocacy programs, patient opinion surveys, medical and nursing audits, and the like.

Patient dissatisfaction

The busy physician and the idle, bed-ridden patient frequently clash in terms of how much time each wants to commit to the exchange of information. When patients are ill or injured they experience a heightened self-awareness and desire information about their illness, treatment and prognosis. Furthermore, the hospitalized patient frequently experiences a time suspension from busy, everyday life. Physicians, on the other hand, may find hospital rounds the most pressing part of the daily schedule. This conflict between patient and physician has been seen as a factor in patient dissatisfaction with the physician.

Hospital based patient education programs can reduce this conflict. These programs save the physician's time because physician approved information can be imparted to many patients. The patient's free time is utilized more productively, as well. The physician-patient relationship improves as routine physician rounds become more meaningful because of the education the patient has received. Moreover, educated patients are more likely to comply with a treatment regimen because they understand it.

Enlightened self-interest should motivate the physician to regard patient education as a realistic necessity, and not as a nebulous adjunct to patient care.

References available from the authors.

Mr. Kippels is an assistant director at Hurley Medical Center, Flint, while Ms. Perry is director of community education and program development and directs the patient advocacy program there.

WHEN ANXIETY AND TENSION MAGNIFY PAIN

IN MUSCULOSKELETAL DISEASE*



A non-narcotic one-two punch against pain, with concurrent relief of anxiety/tension

EQUAGESIC[®] ^{IV}

(meprobamate and ethoheptazine citrate with aspirin) Wyeth

EQUAGESIC—Abbreviated Summary

***INDICATIONS:** Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:

"Possibly" effective for the treatment of pain accompanied by tension and/or anxiety in patients with musculoskeletal disease or tension headache. Final classification of the less-than-effective indications requires further investigation.

The effectiveness of Equagesic in long-term use, i.e. more than four months, has not been assessed by systematic clinical studies. The physician should periodically reassess usefulness of the drug for the individual patient.

CONTRAINDICATIONS: Equagesic should not be given to individuals with a history of sensitivity or severe intolerance to aspirin, meprobamate, or ethoheptazine citrate.

WARNINGS: Careful supervision of dose and amounts prescribed for patients is advised, especially with those patients with known propensity for taking excessive quantities of drugs. Excessive and prolonged use in susceptible persons, e.g., alcoholics, former addicts, and other severe psychoneurotics, has been reported to result in dependence on or habituation to the drug. Where excessive dosage has continued for weeks or months, dosage should be reduced gradually rather than abruptly stopped, since withdrawal of a "crutch" may precipitate withdrawal reaction of greater proportions than that for which the drug was originally prescribed. Abrupt discontinuance of doses in excess of the recommended dose has resulted in some cases in the occurrence of epileptiform seizures.

Special care should be taken to warn patients taking meprobamate that tolerance to alcohol may be lowered with resultant slowing of reaction time and impairment of judgement and coordination.

USAGE IN PREGNANCY AND LACTATION: An increased risk of congenital malformations associated with the use of minor tranquilizers (meprobamate, chlordi-

azapoxide, and diazepam) during the first trimester of pregnancy has been suggested in several studies. Because use of these drugs is rarely a matter of urgency, their use during this period should almost always be avoided. The possibility that a woman of child-bearing potential may be pregnant at the time of institution of therapy should be considered. Patients should be advised that if they become pregnant during therapy or intend to become pregnant they should communicate with their physicians about the desirability of discontinuing the drug.

Meprobamate passes the placental barrier. It is present both in umbilical-cord blood and in near maternal plasma levels and in breast milk of lactating mothers at concentrations two to four times that of maternal plasma. When use of meprobamate is contemplated in breast-feeding patients, the drug's higher concentrations in breast milk as compared to maternal plasma levels should be considered.

Preparations containing aspirin should be kept out of the reach of children. Equagesic is not recommended for patients 12 years of age and under.

PRECAUTIONS: Should drowsiness, ataxia, or visual disturbance occur, the dose should be reduced. If symptoms continue, patients should not operate a motor vehicle or any dangerous machinery.

Suicidal attempts with meprobamate have resulted in coma, shock, vasomotor and respiratory collapse, and anuria. Very few suicidal attempts were fatal, although some patients ingested very large amounts of the drug (20 to 40 gm). These doses are much greater than recommended. The drug should be given cautiously, and in small amounts, to patients who have suicidal tendencies. In cases where excessive doses have been taken, sleep ensues rapidly and blood pressure, pulse, and respiratory rates are reduced to basal levels. Hyperventilation has been reported occasionally. Any drug remaining in the stomach should be removed and symptomatic treatment given. Should respiration become very shallow and slow, CNS stimulants, e.g., caffeine, Metrazol, or am-

phetamine, may be cautiously administered. If severe hypotension develops, pressor amines should be used parenterally to restore blood pressure to normal levels.

ADVERSE REACTIONS: A small percentage of patients may experience nausea with or without vomiting and epigastric distress. Dizziness occurs rarely when meprobamate and ethoheptazine citrate with aspirin is administered in recommended dosage. The meprobamate may cause drowsiness but, as a rule, this disappears as therapy is continued. Should drowsiness persist and be associated with ataxia, this symptom can usually be controlled by decreasing the dose, but occasionally it may be desirable to administer central stimulants such as amphetamine or mephentermine sulfate concomitantly to control drowsiness.

A clearly related side effect to the administration of meprobamate is the rare occurrence of allergic or idiosyncratic reactions. This response develops, as a rule, in patients who have had only 1-4 doses of meprobamate and have not had a previous contact with the drug. Previous history of allergy may or may not be related to the incidence of reactions.

Mild reactions are characterized by an itchy urticarial or erythematous maculopapular rash which may be generalized or confined to the groin. Acute nonthrombocytopenic purpura with cutaneous petechiae, ecchymoses, peripheral edema and fever have also been reported.

More severe cases, observed only very rarely, may also have other allergic responses, including fever, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anaphylaxis, stomatitis and proctitis (1 case), and hyperthermia. Treatment should be symptomatic such as administration of epinephrine, antihistamine, and possibly hydrocortisone. Meprobamate should be stopped, and reinstitution of therapy should not be attempted.

Rare cases have been reported where patients receiving meprobamate suffered from aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis, and hemolytic anemia. In nearly every instance reported, other toxic agents known to have caused these conditions have been associated with meprobamate. A few cases of leukopenia during

continuous administration of meprobamate are reported, most of these returned to normal without discontinuation of the drug.

Impairment of accommodation and visual acuity has been reported rarely.

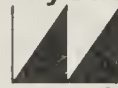
OVERDOSE: Two instances of accidental or intentional significant overdosage with ethoheptazine citrate combined with aspirin have been reported. These were accompanied by symptoms of CNS depression, including drowsiness and tight-headedness with uneventful recovery. However, on the basis of pharmacological data, it may be anticipated that CNS stimulation could occur. Other anticipated symptoms would include nausea and vomiting. Appropriate therapy of signs and symptoms as they appear is the only recommendation possible at this time. Overdosage with ethoheptazine combined with aspirin would probably produce the usual symptoms and signs of salicylate intoxication. Observation and treatment should include induced vomiting or gastric lavage, specific parenteral electrolyte therapy for ketoacidosis and dehydration, watching for evidence of hemorrhagic manifestations due to hypoprothrombinemia which, if it occurs, usually requires whole-blood transfusions.

DESCRIPTION: Each Equagesic tablet contains 150 mg meprobamate, 75 mg ethoheptazine citrate and 250 mg aspirin.

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*This drug has been evaluated as possibly effective for this indication.

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hours as needed



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(65 mg propoxyphene HCl and 650 mg acetaminophen) Wyeth

WYGESIC—Abbreviated Summary

INDICATION: For the relief of mild-to-moderate pain.
CONTRAINDICATION: Hypersensitivity to propoxyphene or to acetaminophen.

WARNINGS: CNS ADDITIVE EFFECTS AND OVERDOSAGE: Propoxyphene in combination with alcohol, tranquilizers, sedative-hypnotics, or other CNS depressants has an additive depressant effect. Patients taking this drug should be advised of the additive effect and warned not to exceed the dosage recommended. Toxic effects and fatalities have occurred following overdoses of propoxyphene alone or in combination with other CNS depressants. Most of these patients had histories of emotional disturbances or suicidal ideation or attempts, as well as misuse of tranquilizers, alcohol, or other CNS-active drugs. Caution should be exercised in prescribing large amounts of propoxyphene for such patients (see **Management of Overdosage**).

DRUG DEPENDENCE: Propoxyphene can produce drug dependence characterized by psychic dependence and less frequently, physical dependence and tolerance. It will only partially suppress the withdrawal syndrome in individuals physically dependent on morphine or other narcotics. The abuse liability of propoxyphene is qualitatively similar to codeine's although quantitatively less, and propoxyphene should be prescribed with the same degree of caution appropriate to the use of codeine.

USAGE IN AMBULATORY PATIENTS: Propoxyphene may impair the mental and/or physical abilities required for potentially hazardous tasks, e.g., driving a car or operating machinery. Patients should be cautioned accordingly.

USAGE IN PREGNANCY: Safe use in pregnancy has not been established relative to possible adverse effects on fetal development. **INSTANCES OF WITHDRAWAL SYMPTOMS IN THE NEONATE HAVE BEEN REPORTED FOLLOWING USAGE DURING PREGNANCY.** Therefore, propoxyphene should not be used in pregnant women unless, in the

judgement of the physician, the potential benefits outweigh the possible hazards.

USAGE IN CHILDREN: Propoxyphene is not recommended for children because documented clinical experience has been insufficient to establish safely and a suitable dosage regimen in the pediatric group.
PRECAUTIONS: Confusion, anxiety, and tremors have been reported in a few patients receiving propoxyphene concomitantly with orphenadrine. The CNS depressant effect of propoxyphene may be additive with other CNS depressants, including alcohol.

ADVERSE REACTIONS: The most frequent adverse reactions are dizziness, sedation, nausea, and vomiting. These seem more prominent in ambulatory than in nonambulatory patients, some of these reactions may be alleviated if the patient lies down. Other adverse reactions include constipation, abdominal pain, skin rashes, light-headedness, headache, weakness, euphoria, dysphoria, and minor visual disturbances. The chronic ingestion of propoxyphene in doses over 800 mg per day has caused toxic psychoses and convulsions. Cases of liver dysfunction have been reported.

DRUG INTERACTIONS: Propoxyphene in combination with alcohol, tranquilizers, sedative-hypnotics, and other CNS depressants has an additive depressant effect. Patients taking this drug should be advised of the additive effect and warned not to exceed the dosage recommended. (see **Warnings**)
Confusion, anxiety, and tremors have been reported in a few patients receiving propoxyphene concomitantly with orphenadrine.

MANAGEMENT OF OVERDOSAGE: SYMPTOMS
The manifestations of serious overdosage with propoxyphene are similar to those of narcotic overdosage and include respiratory depression (a decrease in respiratory rate and/or tidal volume, Cheyne-Stokes respiration, cyanosis), extreme somnolence progressing to stupor or coma, pupillary constriction, and circulatory collapse. In addition to these characteristics, which are reversed by narcotic antago-

nists such as naloxone, there may be other effects. Overdoses of propoxyphene can cause delay of cardiac conduction as well as focal or generalized convulsions, a prominent feature in most cases of severe poisoning. Cardiac arrhythmias and pulmonary edema have occasionally been reported, and apnea, cardiac arrest, and death have occurred.

Symptoms of massive overdosage with acetaminophen may include nausea, vomiting, anorexia, and abdominal pain, beginning shortly after ingestion and lasting for 12 to 24 hours. However, early recognition may be difficult since early symptoms may be mild and nonspecific. Evidence of liver damage is usually delayed. After the initial symptoms, the patient may feel less ill, however, laboratory determinations are likely to show a rapid rise in liver enzymes and bilirubin. In case of serious hepatotoxicity, jaundice, coagulation defects, hypoglycemia, encephalopathy, coma, and death may follow. Renal failure due to tubular necrosis, and myocardiopathy, have also been reported.

Ingestion of 10 grams or more of acetaminophen may produce hepatotoxicity. A 13-gram dose has reportedly been fatal.

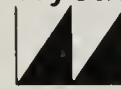
TREATMENT: Primary attention should be given to the reestablishment of adequate respiratory exchange through provision of a patent airway and institution of assisted or controlled ventilation. The narcotic antagonists, naloxone, nalorphine, and levallorphan, are specific antidotes against the respiratory depression produced by propoxyphene. An appropriate dose of one of these antagonists should be administered, preferably IV, simultaneously with efforts at respiratory resuscitation and the antagonist should be repeated as necessary until the patient's condition remains satisfactory. In addition to a narcotic antagonist, the patient may require careful titration with an anticonvulsant to control seizures. Analeptic drugs (e.g., caffeine or amphetamine) should not be used because of their tendency to precipitate convulsions.

Oxygen, IV fluids, vasopressors and other supportive measures should be used as indicated. Gastric lavage may be helpful. Activated charcoal can absorb a significant amount of ingested propoxyphene. Dialysis is of little value in poisoning by propoxyphene alone. Acetaminophen is rapidly absorbed, and efforts to remove the drug from the body should not be delayed. Copious gastric lavage and/or induction of emesis may be indicated. Activated charcoal is probably ineffective unless administered almost immediately after acetaminophen ingestion. Neither forced diuresis nor hemodialysis appears to be effective in removing acetaminophen. Since acetaminophen in overdose may have an antidiuretic effect and may produce renal damage, administration of fluids should be carefully monitored to avoid overload. It has been reported that mercaptamine (cysteine) or other thiol compounds may protect against liver damage if given soon after overdosage (8-10 hours). N-acetylcysteine is under investigation as a less toxic alternative to mercaptamine, which may cause anorexia, nausea, vomiting, and drowsiness. Appropriate literature should be consulted for further information. (JAMA 237:2406-2407, 1977)

Clinical and laboratory evidence of hepatotoxicity may be delayed up to one week. Acetaminophen plasma levels and half-life may be useful in assessing the likelihood of hepatotoxicity. Serial hepatic enzyme determinations are also recommended.

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Oakland County Medical Society membership campaign gets results

By Shelton Reece, special to Michigan Medicine



The Oakland County Medical Society is completing the first major phase of a membership recruitment project begun by the 1,050-member organization last summer.

The campaign, headed by David R. Calver, MD, chairman of OCMS' Membership Committee, not only is important to Oakland County, but will serve as a pilot study for a similar project planned by the Michigan State Medical Society. It also has been closely monitored by the American Medical Association.

"Results from our recruitment activities have been good, according to experts in the field," says Billy Ben Baumann, MD, OCMS president and chairman of MSMS' Membership Recruitment and Retention Committee. "We have had 54 responses from our seven direct mail efforts, have 10 applications for membership, and expect more to apply."

Direct mail

Doctor Baumann points out the major part of the campaign has been

accomplished by direct mail.

The seven mailings consisted of three separate communications containing OCMS Bulletins, a letter of invitation, and a return coupon; then an AMA letter (sent from Chicago) accompanied by AMA literature and a return coupon; next a letter sent under the signature of Marvin L. Starman, MD, then OCMS president, with an annual meeting announcement; a letter and brochure two months later from John R. Ylvisaker, MD, then MSMS President-elect, "12 Reasons Why You Should Be a Member of the Oakland County Medical Society" (this also contained a return coupon); and, finally, a letter from Doctor Baumann with the "12 Reasons" brochure and a general membership meeting announcement.

Return coupons had three boxes that could be checked by potential members. Their choices were: to receive additional information by mail; to receive a phone call from a society officer to explain the benefits of membership; or to receive an application.

Following the direct mail campaign, members of the committee studied the list of names of physicians who did not join the society. The list was divided and each com-

mittee member took the responsibility of personally contacting potential applicants who serve on his/her hospital staff.

Survey ahead

The next step, according to Doctor Baumann, will be a survey of what has been accomplished by recruitment efforts.

"This survey will identify physicians who responded to our mailings," he says. "It will determine why those who joined did so at that time and what was the deciding factor for them.

"For those who replied but did not join, we will, of course, try to learn why. In other words, we will seek to find out what was positive and negative about our efforts and how those efforts can be made more effective in our continuing recruitment endeavors.

"The information we have gained so far in the campaign shows that none of the physicians voiced objections to organized medicine," says Doctor Baumann.

This article is part of a series on the activities of component medical societies.

(continued on next page)

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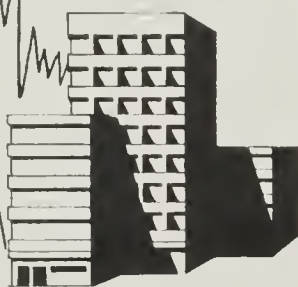


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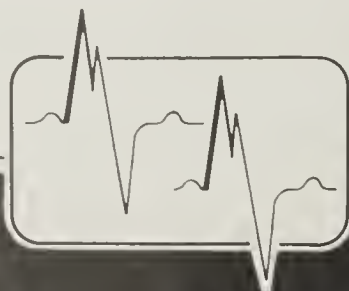
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OCMS/continued

"So far as we can tell, the basic reasons some physicians are not members are that many of them are new and have never been asked, some are recently out of medical schools and think the dues are more than they can afford, and some have intended to join but just have not gotten around to doing it."

Among other plans in the Oakland County Medical Society recruitment campaign will be a permanent effort targeted at physicians who recently have applied for hospital staff memberships but who have not applied for membership in the OCMS. House officers will be approached to get them to apply for associate membership, and students also may be contacted.

Most difficult

"The most difficult part of our campaign," Doctor Baumann continues, "was to compile an accurate mailing list. The second most difficult thing has been to keep the list current. The only sure way we have found to purify mailing lists is to send letters by first class mail so that we get undeliverable ones back and then can check to determine if the physician has moved from the county or whatever."

"Our first mailings were by bulk mail and we thought we had covered our audiences well," he recalls. "Only when we used the higher cost first class did we really learn that a mailing list is something that requires constant updating."

"When we started, we thought there were about 900 physicians in the county who were not members," Doctor Baumann says. "Research proved there were a little more than 400, but, of course, that number keeps changing. We believe we have developed a system, by continually checking various lists, which will assure that we offer membership to every physician in our county and to every new one who begins practice here."

An honor

"That's really what our committee's work is all about. The Oakland Society will be 150 years old next year and is the second largest in the state. I personally feel it is an honor to belong to the Society as well as to the AMA and MSMS and that the dues — while admittedly high, like everything else these days — are by no means exorbitant."

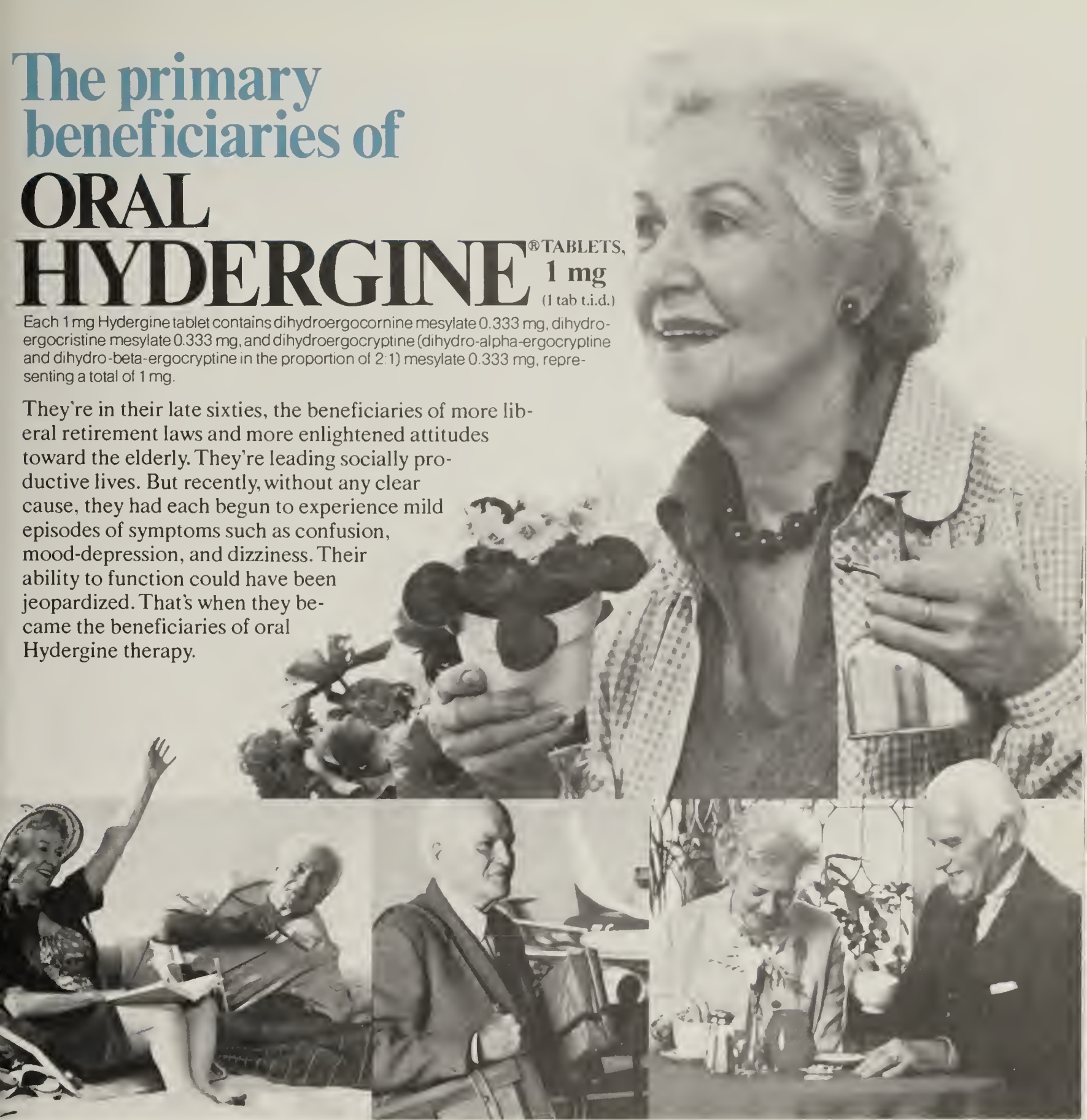
"When you seriously consider the many advantages of being a member of the medical societies, you see that the dues are a very good investment. This is true not only for the day-to-day personal benefits we receive, but also because such organizations are responsible for preserving the medical profession as we know it today and for keeping the standards of medical practice so high. These organizations are by far the most potent socio-economic and political tools that physicians have. They are much more potent than specialty groups."

While admitting that the committee does not yet know if their recruitment campaign has been cost-effective, Doctor Baumann emphasizes they will continue to pare costs as they gain more expertise in recruitment.

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They're in their late sixties, the beneficiaries of more liberal retirement laws and more enlightened attitudes toward the elderly. They're leading socially productive lives. But recently, without any clear cause, they had each begun to experience mild episodes of symptoms such as confusion, mood-depression, and dizziness. Their ability to function could have been jeopardized. That's when they became the beneficiaries of oral Hydergine therapy.



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Communications could improve psychiatrists', other MDs' rapport

By Willah Weddon, special to Michigan Medicine



Doctor Werner

It's no secret that many physicians are biased against psychiatrists. Arnold Werner, MD, professor of psychiatry at Michigan State University in East Lansing, contends this situation could be improved, however, by better communications between the two branches of medicine.

He recommends psychiatrists supply referring physicians with guidelines on how to deal with the

returning patient; "not lengthy explanations about what's happened to the patient, but directions so they can continue to care for the psychiatric patient," he explains.

"On the other hand, referring physicians have to be clear in their communications with psychiatrists about what they hope to see accomplished," he continues. "This exchange around the problem leads to many benefits."

Doctor Werner is in a unique position to discuss the criticisms leveled at psychiatry. He began research two years ago in people's concerns about the profession with a colleague, Horacio Fabrega, Jr., MD.

"It is not a statistical type of study," Doctor Werner said. "We analyzed medical and other literature and examined the criticisms in the

context of Western social history and culture.

"We examined the various interfaces between psychiatry and other elements of society — medicine, legal establishments, religious groups and general issues involving society as a whole," he said, adding that colleagues in the field feel it is an accurate portrayal of the problems they face today.

Doctor Werner thinks all psychiatrists should reach out more to help their medical colleagues. "We can make ourselves more accessible," he says.

"We can give family physicians a better understanding of psychiatry by presenting papers at their meetings, publishing articles in their

(continued on page 266)

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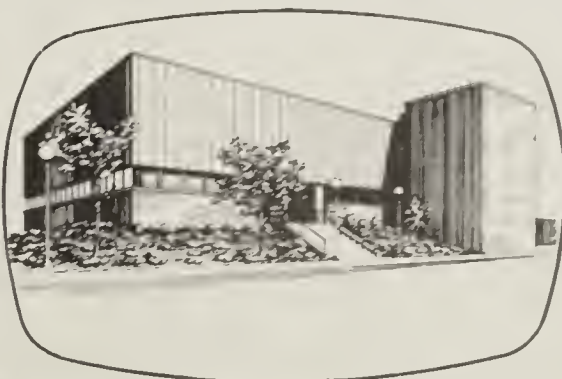
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DOCTOR WERNER/continued journals and perhaps sending newsletters to all practitioners," he says. "Medical physicians know they face difficulties in dealing with the emotional problems of their patients and many want our advice. We should make it more easily available.

"Support for the psychiatric profession from other physicians is important to the success of our work with their patients, since patients so often are guided by the attitudes and statements of their doctors," he continues. "The willingness of primary care physicians to talk more with their patients would help in facilitating referrals as well.

"We should also see to it that our training programs emphasize consultations more," Doctor Werner emphasizes. He is in a position to be effective in this area as he directs the medical student programs in psychiatry at MSU's colleges of medicine. A 1963 graduate of the University of Rochester (New York) School of Medicine, he interned a year at Vanderbilt University, returned for three years in psychiatry at Rochester and spent two years on the faculty of

Temple University (Pennsylvania) before coming to MSU in 1970.

Psychiatrists can improve their image by taking public stands on issues involving patient care and patients' rights, he says with conviction. For example, he says there is the present move to "de-institutionalize," or more correctly, "trans-institutionalize" the chronic mentally ill. Psychiatrists should let people know what they think about these situations, he feels.

"People now are going from large to smaller institutions, such as nursing homes, single-room occupancy set-ups, half-way houses and so forth," he says.

"Some facilities are awful. Patients don't see a health professional at all, there is a limited range of activities, and there are many patients who are under-stimulated in their environment.

"Some chronically ill patients can't be helped through treatment, but they could benefit from appropriate activities," he continues. "The quality of care for people is a major concern.

"The best situation would be to

have patients in small quality care facilities, supported with out-patient center activities," he says. "That was the basis for the present community mental health movement, but it's been more talk than delivery.

Psychiatry is at a critical juncture in its development, says Doctor Werner. He contends psychiatry must be concerned with generating new knowledge about psychiatric disease and refining old knowledge.

"As a part of the larger institution of medicine, psychiatry and psychiatrists receive the same criticisms that society directs at medicine and physicians in general," he says. "However, by virtue of its unique concerns, its area of work and the theoretical and practical positions it takes, psychiatry is the target of additional criticisms.

"To have a psychiatric problem is stigmatizing," Doctor Werner elaborated. "When a person has a severe emotional problem and receives help, he doesn't go around telling everybody about the great help he received. So psychiatry has more exposure to negative things than positive things. That's the way it is."

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John A. Gronvall, MD, dean of the University of Michigan Medical School, has been appointed to the Liaison Committee on Medical Education, the official body responsible for medical school accreditation in the United States and Canada. . . . The California Medical Association has given the first annual **Frederick K. M. Plessner Memorial Award** to **James R. Fassett, MD**, Gonzales, California. The award was established in memory of a Michigan native who was the son, grandson and great-grandson of physicians. His will established the award for the physician "who best exemplifies the ethics and practice of a rural country practitioner." . . . **James Harrison, MD**, Lansing, has assumed a position with the State Health Department. In his new post, Doctor Harrison is medical co-ordinator for the Office of Local Health Services for the Michigan Department of Public Health. . . . Detroit Medical Society officers for 1980 include **George A. Lightbourn, MD**, president; **James A. Feemster, MD**, vice-president and **Anne-Maré Ice, MD**, secretary. . . . **William D. Ensminger, PhD, MD**, has been named Burroughs Wellcome Scholar in Clinical Pharmacology. The \$200,000 award was made to support Doctor Ensminger's cancer research, teaching and training programs in clinical pharmacology at the U-M Medical School's Upjohn Center for Clinical Pharmacology. Doctor Ensminger is the first U-M faculty member to receive the award and one of only two recipients of the national honor this year. . . . **Virginia Delany Black, MD** Detroit, has been appointed associate neonatologist at Hutzel Hospital in the Detroit Medical Center. Hutzel is the most active maternity center in Michigan, annually delivering almost 6,000 infants. . . . The AMA Board of Trustees approved **Jay K. Harness, MD**, Detroit, as chairman of the AMA Jail Project Committee. . . . **Dan C. English, MD**, professor and chairman of surgery at Michigan State University's College of Human Medicine, is one of six national recipients of Robert Wood Johnson Health Policy Fellowships for a year's study and congressional work assignments in Washington, DC. The fellowship program is designed to provide a better understanding of major issues in health policy. . . . **E. Marshall Gold-**

berg, MD, Flint, was the correspondent for three segments of a program Feb. 5, 6 and 7 on ABC TV's World News entitled, "Heart Attacks: New Cures, New Hopes?" . . . **Joseph A. Sentkeresty, MD**, Grand Rapids, is a nominee for a three year term as a trustee on the nine member American Society of Internal Medicine Board of Trustees. . . . New president of the Michigan Health Council Board of Trustees is **Robert L. Tupper, MD**, Grand Rapids. He succeeds Doctor **C. Allan Payne** who will continue on the MHC Board for a three-year term. . . . **William Carley, MD**, Lansing, associate director of the Lansing Family Practice Center, has been selected as a test writer for the American Board of Family Practice. . . . The first M. H. Seevers International Fellowship in Pharmacology was awarded **Jesus A. Garcia-Sevilla, MD, PhD**, Spanish pharmacologist who has come to Ann Arbor to train and do research. The fellowship, given by the University of Michigan Medical School, was established as a memorial to the late **Maurice H. Seevers, MD, PhD**, an internationally known expert on drugs and an emeritus professor of pharmacology at the U-M. . . . **Doctor Kuno Hammerberg**, who practiced medicine more than four decades in the Upper Peninsula before his recent retirement, has authored a book entitled, "Kuno: One of the Last of the General Practitioners." In his book, Doctor Hammerberg shares some of his experiences and adventures during his early days of practice. . . . **Edwin Lark, MD**, Charlotte, has assumed the position of Ionia County Public Health Director in a cooperative program with Eaton County. Under the program, Doctor Lark will divide his time between the two areas. . . . **Anna L. Davol, MD**, is new acting director of the University of Michigan Health Service. **Doctor Robert E. Anderson** stepped down as director to return to the staff as a senior physician. . . . **Roscoe J. Fortner, MD**, Three Rivers, was featured in a recent article in the *Three Rivers Commercial*. The retired general practitioner reflected on the changes he has seen in medicine during the six decades of his career.

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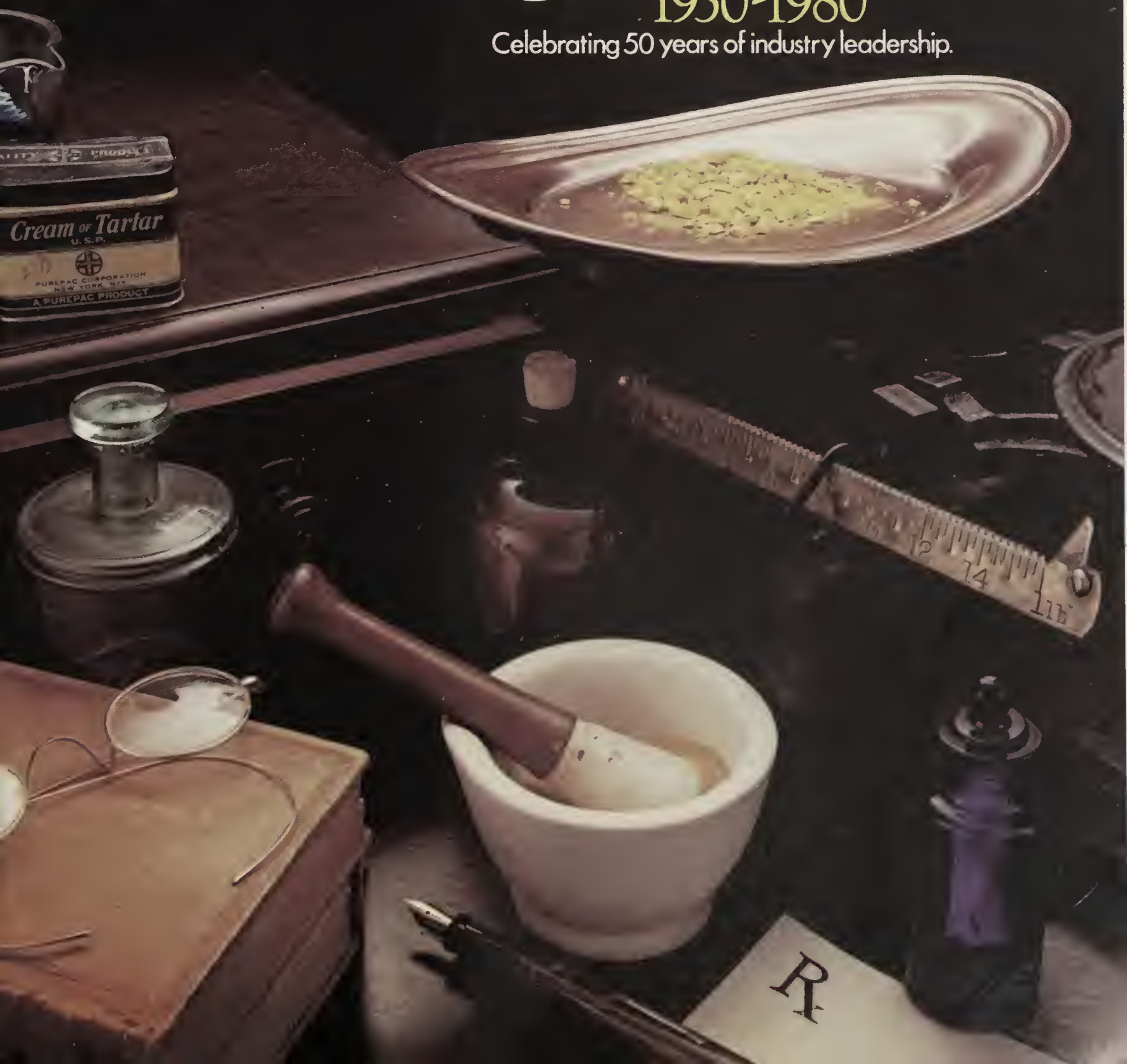
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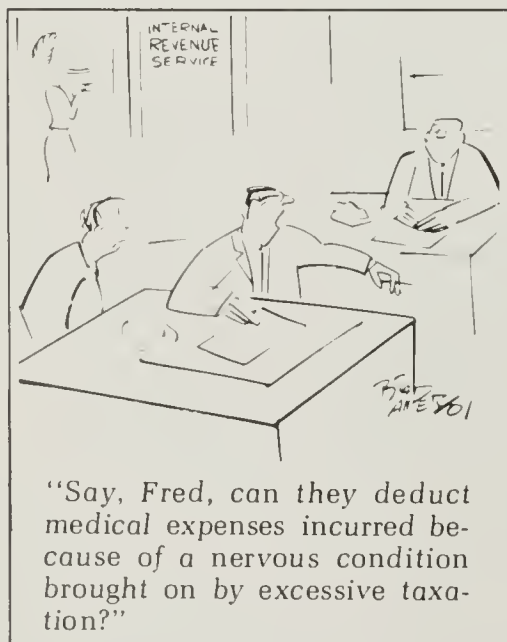
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May 29-30 — Annual Gull Lake Conference, MSMS Maternal Health Conference, contact: Katie Brewbaker, MSMS headquarters.

June 13-14 — AMA "New Directions for Medical Care — A Challenge of the 80's," Boston, contact: AMA, Dept. of Hospitals and Health Facilities, 535 N. Dearborn St., Chicago, IL 60610.

June 15-17 — AMA National Conference on Negotiating Physicians' Compensation, Loew's L'Enfant Plaza, Washington, DC, contact: AMA Department of Negotiations, 535 North Dearborn Street, Chicago, 60610.

July 10-13 — MSMS Council, Holiday Inn, Marquette, contact: Warren Tryloff, MSMS headquarters.

July 26-27 — Summer Seminar, State of Michigan Branch, American Association of Medical Assistants, Marquette, contact: Caroline Rich, MSMS headquarters.

Sept. 10 — MSMS Council, MSMS headquarters, contact: Warren Tryloff, MSMS headquarters.

Sept. 10-18 — MSMS/Intrav Swiss Adventure, contact: Marcelyn Ireland, MSMS headquarters.

Sept. 10-29 — MSMS/Intrav China Adventure, contact: Marcelyn Ireland, MSMS headquarters.

Oct. 22 — MSMS Council, MSMS headquarters, contact: Warren Tryloff, MSMS headquarters.

Oct. 24-25 — AMA Fourth National Conference on Medical Care and Health Services in Correctional Institutions, Chicago, contact: AMA Correctional Programs, 535 N. Dearborn St., Chicago, 60610.

Nov. 18-20 — MSMS Annual Scientific Meeting, Hyatt Regency Dearborn, contact: Sherry L. Fent, MSMS headquarters.

Dec. 3 — MSMS Council, MSMS headquarters, contact: Warren Tryloff, MSMS headquarters.

Other meetings

May 17-18 — Sexuality Training for Professionals, at Michigan League,

Ann Arbor, contact: Michael Brown, 6869 Marshall Rd., Dexter, 48130.

May 21-23 — Michigan Hospital Association Medical Staff/Trustee/Administrator Forum, Boyne Mountain Lodge, contact: Michigan Hospital Association, 2213 E. Grand River Ave., Lansing, 48912.

May 27-30 — 59th Annual Conference, Michigan Public Health Association, Kalamazoo Center Hilton Inn, contact: Michigan Public Health Association, 403 N. Seymour, Lansing, 48914 (517) 484-3044.

May 28-30 — Seventh Annual Michigan Emergency Medicine Assembly, Michigan Chapter, American College of Emergency Physicians, Grand Hotel, Mackinac Island, contact: Susan Aldrich, Michigan Chapter ACEP, 1305 Abbott Rd., Suite 102, P.O. Box 1611, East Lansing, 48823.

May 29-31 — 1980 National Conference on Trustees, American Hospital Association, Renaissance Center, Detroit, contact: American Hospital Association, 840 N. Lakeshore Dr., Chicago, 60611.

June 9 — Annual Meeting, Wayne County Medical Society, Wayne County Medical Society headquarters, Detroit, contact: Roger Mecum, Wayne County Medical Society, 1010 Antietam Rd., Detroit, 48207.

June 13-15 — Annual Meeting, Michigan Dermatological Society, Bay Valley Inn, Bay City, contact: Alejandro Morales, MD, Dept. of Dermatology, Henry Ford Hospital, 2799 W. Grand Blvd., Detroit, 48202.

June 13-15 — Annual Meeting, Michigan Chapter, American College of Chest Physicians, at Boyne Highlands, Boyne City, contact: Susan Gibson, American Lung Association of Southeast Michigan, 28 W. Adams, Detroit, 48226, 313/961-1697.

June 26-27 — Annual Meeting, Michigan Hospital Association, Grand Hotel, Mackinac Island, contact: Michigan Hospital Association, 2213 E. Grand River Ave., Lansing, 48912.

July 8-10 — Annual Scientific Meeting, Michigan Chapter, American Academy of Pediatrics, Bay Valley Inn, Bay City, contact: Miles Tiernan, 32245 Hearthstone, Farmington Hills, 48018, 313/553-3646.



The MSMS Medicaid Liaison Committee, government and legislative leaders share concerns about the Michigan Medicaid program, due to governmental fiscal restraints, increasing unemployment and Medicaid payments, and about problems with cost containment proposals such as the new Medicaid second surgical opinion program. From left are committee member Thomas M. Flake, MD; Sherry Wellman, MSMS staff; committee chairman David Siegel, MD; Medicaid staff member Vern Smith, PhD, and Medicaid Director Paul Allen.



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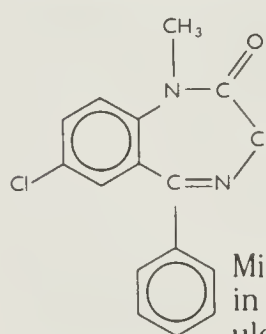
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Misunderstanding of directions resulted in discrepancies in dosage schedules as well as in length of therapy.

Since evidence suggests that expanded verbal instructions may encourage compliance, the patient receiving Valium can benefit from your explanation of the dosage regimen, what response to expect from therapy and when to expect it.

What Valium

(diazepam/Roche) can do

Your patients should know that 1) you are prescribing Valium as an adjunct to an overall program for the treatment of anxiety, and 2) Valium is given to relieve the symptoms of excessive anxiety and psychic tension while you help the patient to explore and deal with the underlying cause of his psychic tension.

Patients often interpret manifestations of anxiety, such as palpitations, hyperventilation, fatigue and muscle tension, as symptoms of a serious disease. However, when they

learn that these symptoms can be relieved by Valium therapy, patients can more readily understand the psychosomatic origin of their symptoms and to accept the nonpharmacologic measures you may recommend.

The time you devote to these explanations can be a therapeutic measure in itself. Most anxious patients respond to and benefit from a frank discussion with an objective, sympathetic professional.

At the start of treatment, establishing therapeutic goals helps the patient to learn *what* to expect and *when* to expect it. Patients should also be informed that the medication will be gradually reduced and discontinued upon attainment of the therapeutic goal.

Tapering of dosage is rarely necessary in short-term therapy, but when consistently higher doses are used for extended periods, patients should know that the gradual reduction of medication will be implemented in order to avoid sudden recurrence of symptoms or possible withdrawal symptoms.

Such recurrence is unlikely when the causes of the anxiety have been worked out satisfactorily within your overall treatment program.

What Valium

(diazepam/Roche) can't do

It should be emphasized that there is no "magic" in any antianxiety tablet; that medication is not prescribed as a problem solver. Instead, Valium is being prescribed *as a temporary measure to relieve symptoms* generated by excessive anxiety and psychic tension.



* Boyd JR, et al: *Am J Hosp Pharm* 31: 485-491, May 1974

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety associated with anxiety disorders, transient situational disturbances and functional or organic disorders, psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms, or agitation. Symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal, adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders; athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy). The effectiveness of Valium (diazepam/Roche) in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma, may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders,

possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms similar to those with barbiturates and alcohol have been observed with abrupt discontinuation, usually limited to extended use and excessive doses. Infrequently, milder withdrawal symptoms have been reported following abrupt discontinuation of benzodiazepines after continuous use, generally at higher therapeutic levels, for at least several months. After extended therapy, gradually taper dosage. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed, drugs such as phenothiazines, narcotics,

Practical pointers on taking anxiety medications

do's Patients should be instructed to keep to their dosage schedule exactly as prescribed. If they miss a dose, they should not try to make it up by taking two doses the next time. Ask them to contact you promptly if they experience worrisome side effects.

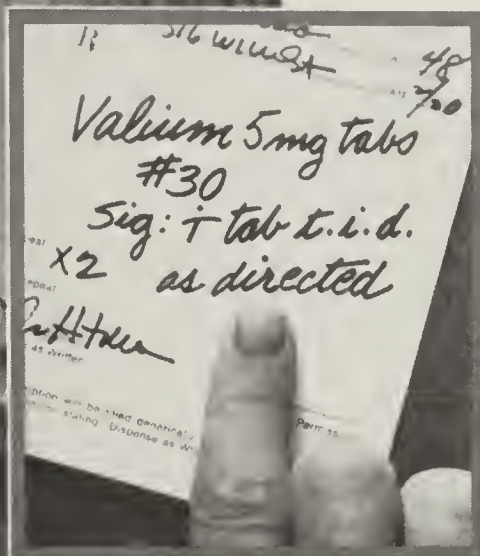
Explain that drowsiness is a common reaction to almost all calming agents, but that it usually subsides in a few days. Urge the patient to contact you for a possible dosage adjustment if drowsiness or other reactions persist.

Just as you request a complete list of all medications the patient is taking, suggest that this list be given to any other physician treating her/him.

Like all medicines, Valium should be kept out of reach of children and young people. Old or unused medication should be discarded.

and don'ts Since drowsiness is an occasional problem, patients should be advised against driving or operating hazardous machinery until they see how the medication affects them. They should also know that tranquilizers increase the effects of alcoholic beverages, which should therefore be avoided. Also, warn patients against simultaneous use of drugs that depress the central nervous system, particularly sedative hypnotics.

Patients should be aware of the importance of not sharing their medications with friends and neighbors; they should know that what you have prescribed for them may be contraindicated for others.



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Dosage: Individualize for maximum beneficial effect. *Adults:* Tension, anxiety and psychoneurotic states, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d., adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. *Geriatric or debilitated patients:* 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) *Children:* 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

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barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported. Should these occur, discontinue drug. Isolated reports of neutropenia, jaundice, periodic blood counts and liver function tests advisable during long-term therapy.

CATEGORY I COURSES

Michigan Medicine each month carries a list of opportunities in Michigan for doctors of medicine to obtain Category I credit toward meeting the requirements of Michigan law. Sponsors of Category I programs and courses in Michigan are invited to submit information for the monthly calendar.

Each listing below, of programs that carry at least 3 hours of Category I credit, indicates a contact person, so the physician can obtain details. Physicians with questions about accredited programs may phone MSMS Headquarters, 517/337-1351.

Date: May 12-14, **Current Perspectives in Ophthalmology: Spring Conference.** **Location:** Towsley Center, Ann Arbor. **Sponsor:** U-M Office of Continuing Medical Education. **For:** Ophthalmologists. **Cost:** \$175. **Contact:** Towsley Center for CME, 313/764-2287. **Approved for:** 17 hours of Category I Credit.

Date: May 12-16, **Head and Neck Oncology.** **Location:** Towsley Center, University of Michigan. **Sponsor:** U-M Office of Continuing Medical Education. **For:** All interested physicians. **Cost:** \$500. **Contact:** Towsley Center for CME, 313/764-2287. **Approved for:** 42½ hours of Category I Credit.

Date: May 15-16, **Seminar and Workshop of Fine and Large Needle Biopsies of the Thyroid Gland.** **Location:** Education and Research Center, Henry Ford Hospital, Detroit. **Sponsor:** Henry Ford Hospital. **For:** All interested physicians. **Cost:** \$250. **Contact:** Medical Education, Henry Ford Hospital, 2799 W. Grand Blvd., Detroit, 48202 (313) 876-1464. **Approved for:** 15½ hours of Category I Credit.

Date: May 17, **Regional Oncology Symposium.** **Location:** General Motors Institute, Flint. **Sponsor:** Hurley Medical Center. **For:** All interested physicians. **Contact:** Richard D. Garlick, Hurley Medical Center, Sixth Ave. and Begole, Flint 48502 313/766-0142. **Approved for:** 6 hours of Category I Credit.

Date: May 19-23, **Advances in Internal Medicine.** **Location:** Towsley Center, U-M. **Sponsor:** U-M Office of Continuing Medical Education. **Cost:** \$290. **Contact:** Towsley Center for CME, 313/764-2287. **Approved for:** 35 hours of Category I Credit.

Date: May 21, 1980, **Medical Therapy in Family Practice.** **Location:** Saint John Hospital. **Sponsor:** CME Committee of Saint John Hospital. **For:** All interested physicians. **Cost:** \$90. **Contact:** Ms. Linda Radu, Secretary, Continuing Medical Education, Department of Health Education, Saint John Hospital, 22101 Moross Road, Detroit 48236 (313/343-4000). **Approved for:** 8 hours of Category I Credit.

Date: May 24, **"Care of the Injured Hand."** **Location:** Detroit Plaza Hotel. **Sponsor:** American Association for Hand Surgery and Michigan Academy of Plastic Surgeons. **For:** All interested physicians. **Cost:** \$75. **Contact:** Kim K. Lie, MD, 313/759-2500. **Approved for:** 7 hours of Category I Credit.

Date: May 27, **Infectious Diseases Symposium.** **Location:** Butterworth Hospital, East Auditorium. **Sponsor:** Butterworth Hospital. **For:** All interested physicians. **Cost:** \$40. **Contact:** Butterworth Hospital Medical Education Office, 100 Michigan, N.E., Grand Rapids, 49503 616/774-1835. **Approved for:** 7 hours of Category I Credit.

Date: May 30-31, **Neurological Update.** **Location:** Education & Research Center, Henry Ford Hospital, Detroit. **Sponsor:** Henry Ford Hospital. **For:** All interested physicians. **Cost:** \$135. **Contact:** Medical Education, Henry Ford Hospital, 2799 W. Grand Blvd., Detroit, 48202 (313) 876-1464. **Approved for:** 12 hours of Category I Credit.

Date: June 5-6, **Blood Banking.** **Location:** Towsley Center, Ann Arbor. **Sponsor:** U-M Office of Continuing Medical Education. **For:** All interested physicians. **Cost:** \$125. **Contact:** Towsley Center for CME, 313/764-2287. **Approved for:** 12½ hours of Category I Credit.

Date: June 5-6, **Michigan Occupational Medical Association Annual Meeting.** **Location:** Bay Valley Inn, Bay City. **Sponsor:** Michigan Occupational Medical Association. **For:** All interested physicians. **Contact:** Joann Madden, 313/766-3252. **Approved for:** 4 hours of Category I Credit.

(continued on page 280)

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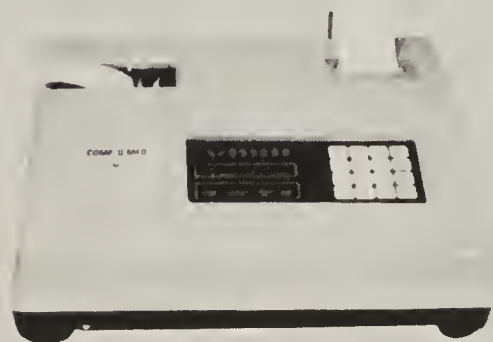
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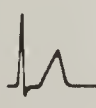


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CATEGORY I COURSES/continued

Date: June 11, **First Annual Regional Medical Conference on Infectious Disease.** **Location:** Southwestern Community College, Dowagiac. **Sponsor:** Lee Memorial Hospital and Southwestern Michigan Area Health Education Center. **For:** All interested physicians and health personnel. **Cost:** Advance: \$35 physicians, \$20 allied health personnel; Walk-in: \$45 physicians, \$30 allied health personnel. **Contact:** Judith B. Willis, MD, PA-C, SMAHEC, 252 East Lovell, Kalamazoo, 49007, 616/383-6360. **Approved for:** 6 hours of Category I Credit.

Date: June 19-21, **31st Annual Keyport-Gaylord Trauma Symposium.** **Location:** Hidden Valley Club, Gaylord. **Sponsor:** Michigan Committee on Trauma, A.C.S. **Cost:** \$30. **Contact:** Theresa Sokol, Dept. of Surgery, Wayne State Univ., 540 E. Canfield, Detroit, 48201. **Approved for:** 12 hours of Category I Credit.

Date: June 22-27, **16th Annual Northern Michigan Summer Conference.** **Location:** Shanty Creek, Bellaire. **Sponsor:** U-M Office of Continuing Medical Education. **For:** All interested physicians. **Cost:** \$225. **Contact:** Towsley Center for CME, 313-764-2287. **Approved for:** 21½ hours of Category I Credit.

Date: July 21-25, **American College of Physicians — MKSAP V Review Course.** **Location:** Education and Research Center, Henry Ford Hospital, Detroit. **Sponsor:** Henry Ford Hospital and American College of Physicians. **For:** All interested physicians. **Cost:** ACP members, FACP, Residents and Research Fellows, \$100; Nonmembers, \$150; ACP Associates \$50. **Contact:** Medical Education, Henry Ford Hospital, 2799 W. Grand Blvd., Detroit, 48202, 313/876-

1464. **Approved for:** 30 hours of Category I Credit.

Date: July 24-25, **Collier Penberthy Thirlby Medical Conference.** **Location:** Park Place Motor Inn, Traverse City. **Sponsor:** Munson Medical Center. **For:** All interested physicians. **Cost:** \$45. **Contact:** Norma Powers, Munson Medical Center, Traverse City, 49684. **Approved for:** 11 hours of Category I Credit.

Date: July 25-27, 1980, **EKG Interpretation and Arrhythmia Management.** **Location:** Grand Hotel, Mackinac Island. **Sponsor:** International Medical Education Corporation. **For:** All interested physicians. **Cost:** \$215.00. **Contact:** International Medical Education Corporation, Division of Postgraduate Education, Dept. 12, 64 Inverness Drive East, Englewood, CO 80112 (800) 525-8646 Toll Free or (313) 773-1144. **Approved for:** 15 hours of Category I Credit.

Date: July 26, **Symposia on Teaching Skills.** **Location:** Holiday Inn, Traverse City. **Sponsor:** American Academy of Family Physicians. **For:** All members of the AAFP. **Contact:** Michigan Academy of Family Physicians, 416 N. Homer, Suite 107, Lansing. **Approved for:** 4 hours of Category I Credit.

Date: July 28-30, **Michigan Academy of Family Physicians 34th Annual Scientific Assembly.** **Location:** Holiday Inn, Traverse City. **Sponsor:** Michigan Academy of Family Physicians. **For:** Members of MAFP. **Contact:** Michigan Academy of Family Physicians, 416 N. Homer, Suite 107, Lansing 48912, 517/337-2065. **Approved for:** 15½ hours of Category I Credit.

Date: July 31-Aug. 3, **Michigan Ophthalmological Society Twelfth Annual Summer Confer-**

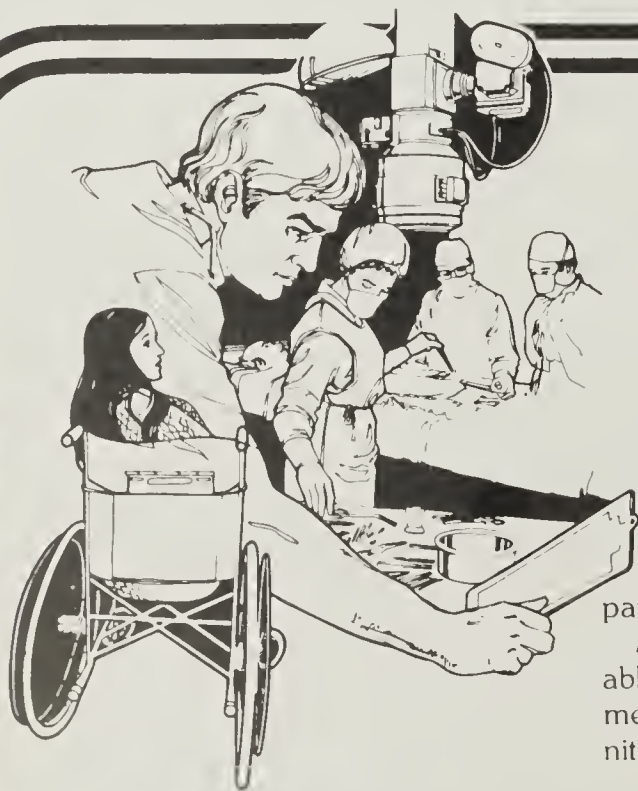
ence. **Location:** Grand Hotel, Mackinac Island. **Sponsor:** Michigan Ophthalmological Society. **For:** Ophthalmologists. **Cost:** \$75. **Contact:** Tanya Miller, MSMS headquarters, 517-337-1351. **Approved for:** 7 hours of Category I Credit.

Date: Aug. 22-25, **6th Annual Mackinac Island Conference.** **Location:** Grand Hotel, Mackinac Island. **Sponsor:** U-M Office of Continuing Medical Education. **For:** All interested physicians. **Cost:** \$150. **Contact:** Towsley Center for CME, 313/764-2287. **Approved for:** 11 hours of Category I Credit.

Date: Aug. 23-24, **Anatomy and Techniques of Regional Anesthesia.** **Location:** Wayne State University School of Medicine, Scott Hall, Detroit. **Sponsor:** Wayne State University. **For:** All interested physicians. **Contact:** Wayne State University School of Medicine, Division of Continuing Medical Education, 9B-32 Health Care Institute, Detroit, 48201. **Approved for:** 12 hours of Category I Credit.

Date: Sept. 25-26, **Nitrosoureas: Current Status and New Developments.** **Location:** Hyatt Regency Dearborn. **Sponsor:** Wayne State University School of Medicine Department of Oncology, Harper-Grace Hospitals and the Comprehensive Cancer Center of Metropolitan Detroit and Bristol Laboratories. **For:** All interested physicians. **Contact:** David Moss, Symposium Coordinator, Bristol Laboratories, P.O. Box 657, Syracuse, NY 13201. **Approved for:** 12 hours of Category I Credit.

Date: Nov. 18-20, **MSMS Annual Scientific Meeting.** **Location:** Hyatt Regency Dearborn. **Sponsor:** Michigan State Medical Society. **For:** All interested physicians. **Contact:** Sherry Fent, MSMS, 517/337-1351. **Approved for:** 18 hours of Category I Credit.



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COMMITTEES

MSMS committees studying state society goals, structure

By Katie Brewbaker, MSMS staff



Inflation, governmental influences, the energy crisis, consumer attitudes, an aging population, new technologies, and a host of other exigencies, many of which we cannot even anticipate at this time, will confront the medical profession in the '80s. And, the time to begin seeking solutions and framing policies is now!

That is the purpose behind the establishment of a new committee appointed by the Michigan State Medical Society — the Committee on Long Range Planning.

Under the leadership of John R. Ylvisaker, MD, Pontiac, the MSMS president and long-time member of the MSMS Council, members of the committee have begun brainstorming sessions to (1) examine current activities of MSMS and (2) identify, categorize, set priorities, and recom-

mend general and specific goals for MSMS now, for the next five years, and throughout the decade.

Each committee member currently is developing a statement of how he or she perceives the environment of the '80s and how it will affect the medical profession. Will national health insurance be a fact of life? How will possible changing transportation patterns due to energy limitations affect the location and function of hospitals and clinics? What are the financial implications of use of new technologies? These are just some of the influences to be considered.

Once the problems have been identified and the goals set, the committee will consider what structure will be required to implement the recommendations in the years ahead.

MSMS has not overlooked this concept, either. A special Task Force on MSMS Structure has been appointed, chaired by Donald N. Sweeny, Jr., MD, Detroit, whose recent service on a similar committee of the American Medical Association makes him uniquely qualified to direct this group.

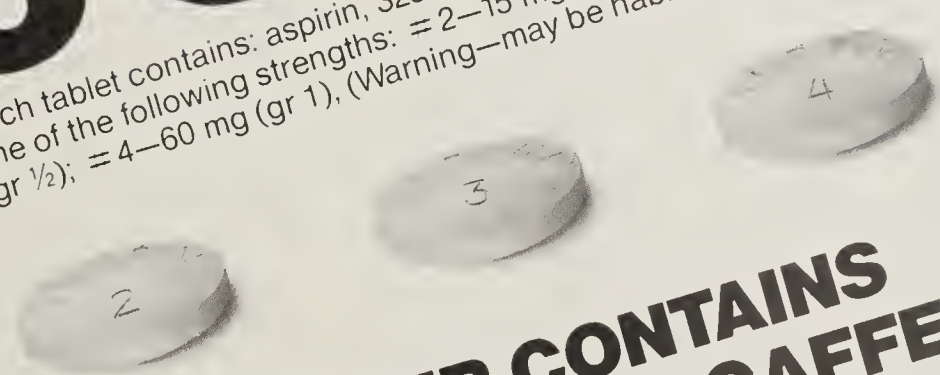
The Task Force already has begun its re-examination of the MSMS structure, analyzing the operation of the House of Delegates, The Council, MSMS committees and task forces. It is investigating how these official bodies best can be representative of and responsive to the MSMS membership. The end result will be an even more streamlined, efficient organization that will respond to the needs of the '80s.

To tackle these two projects, broad-based and divergent committees have been appointed. Serving on the Committee on Long Range Planning are Susan E. Adelman, MD, Southfield; Daniel R. Barr, MD, Warren; Harold I. Blumenstein, MD, Bay City; Donald K. Crandall, MD, Muskegon; Larry W. Fitzsimmons, MD, Lansing; Robert H. Hamburg, MD, Detroit; William R. Harlan, MD, Ann Arbor; Richard C. Hausler, MD, Saginaw; Kenneth E. Pitts, MD, Farmington Hills; Natalia M. Tanner, MD, Detroit, and the following consultants: James T. Maulouf, MD, Southfield; Sheldon F. Markel, MD, Ann Arbor; Mr. Richard Leo, Ann Arbor; Clyde Ying-Chou Wu, MD, Dearborn; Ernest P. Griffin, Jr., MD, Flint; Louis E. Heideman, MD, Birmingham, and Louis R. Zako, MD, Dearborn Heights.

The Task Force on MSMS Structure is composed of Richard D. Anslow, MD, Detroit; Robert D. Burton, MD, Grand Rapids; John J. Coury, MD, Port Huron; Ernest P. Griffin, Jr., MD, Flint; Louis E. Heideman, MD, Birmingham; James J. Humes, MD, Detroit; Philip F. Lange, MD, Lansing; Gerald H. Mandell, MD, Detroit; Robert C. Proffater, MD, Bay City; Marvin L. Starman, MD, Southfield, and George M. Wilson, MD, Marquette.

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DEATHS



Joseph A. Bakst, MD Oak Park

Joseph A. Bakst, MD, Oak Park, died March 15 at the age of 93. A 1911 graduate of Baltimore Medical College, Doctor Bakst practiced in Detroit for nearly 70 years and retired four years ago. In 1962 he was honored by the state of Michigan for 50 years of excellence in practice. Until his retirement Doctor Bakst worked as a general practitioner out of an office in the Warren-Woodward area.

Stanley F. Dolega, MD Grosse Pointe Farms

Stanley F. Dolega, MD, Grosse Pointe Farms, died March 10. He was 67. Doctor Dolega received his MD from Wayne State University School of Medicine in 1938. Prior to his death, Doctor Dolega had been a staff member of Holy Cross Hospital.

Edgar B. Keemer, MD Detroit

Edgar B. Keemer, MD, Detroit, died Feb. 23 at the age of 66. Doctor Keemer was active in the move to legalize abortions in Michigan and was imprisoned for 14 months for conspiracy to perform an abortion. That conviction was set aside in 1975. Upon regaining his license, Doctor Keemer established the still-functioning Keemer Clinic in the David Whitney Building. He received his MD in 1936 from Meharry Medical College in Nashville.

Harley L. Krieger, MD Detroit

Harley L. Krieger, MD, Detroit, died March 8 at the age of 82. Doctor Krieger earned his MD from Wayne State University School of Medicine in 1925. He joined the Ford Motor Co. after graduating and spent his en-

tire career in industrial medicine, helping design plant hospitals in many Ford factories. He was medical director from 1948 to his retirement in 1957. Doctor Krieger was past president of the Wayne County Medical Society and a member of the Ramazzini Society, a select national group of industrial physicians.

Edward E. Levine, MD Huntington Woods

Edward E. Levine, MD, Huntington Woods, died Feb. 13. He was 67. Doctor Levine earned his MD from the University of Illinois Medical School in 1938. He was former chief of radiology at the Veterans Administration Hospital, Allen Park. He was a member of the American College of Radiology and Alpha Omega Alpha, an honorary medical society.

James C. Nora, MD Iron River

James C. Nora, MD, Iron River, died Jan. 26 at the age of 61. Doctor Nora graduated from Wayne State University School of Medicine in 1950. He had served with the U.S. Army for four years during WW II in the Pacific Theater as a captain in the field artillery. He began his medical practice in Iron River in 1953 and was practicing at the time of his death. He was medical director of the Iron County Medical Care Facility and chief Iron County medical examiner.

Burn center gets Kellogg Grant

The W.K. Kellogg Foundation has awarded the University of Michigan \$500,000 for a three year period to improve the treatment of burn patients in the Great Lakes region.

Part of the funds will be used to increase related educational programs through the strengthening and expansion of the University of Michigan Burn Center.

Half of the grant will be applied toward developing educational facilities within the Center. The expanded Center will combine the burn care services currently provided at University Hospital, St. Joseph Mercy Hospital, and Chelsea Community Hospital. The new facilities will benefit Michigan citizens by providing the complete range of patient care services required to treat victims of serious burns and to prepare health professionals in burn medicine.

The Foundation grant also will support the establishment of an interdisciplinary educational program. Through this program the Burn Center personnel will work with the faculty and staff of the Medical School, School of Nursing, School of Public Health, College of Pharmacy, and other U-M units.

Lastly, part of the grant will be subcontracted to the National Institute for Burn Medicine (NIBM) for preparation of new instructional materials.

The entire project will be directed by Irving Feller, MD, U-M clinical professor of surgery, medical director of the U-M Burn Program, and president of NIBM. It will be administered through the U-M Medical School's department of surgery and operated by the University Hospital.

William F. Mertaugh, MD Sault Ste. Marie

William F. Mertaugh, MD, Sault Ste. Marie, died Nov. 8. He was 82. Doctor Mertaugh received his MD from Wayne State University School of Medicine in 1927. He was a past president of the Chippewa County Medical Society and was affiliated with War Memorial Hospital prior to his death.

Alexander W. Pietra, MD Grosse Pointe

Alexander W. Pietra, MD, Grosse Pointe, died Feb. 23. He was 83. A graduate of Albany Medical School in Albany, NY, Doctor Pietra practiced medicine in Detroit for 50 years. He was a member of the Wayne County Medical Society.

CLASSIFIED

The rate for each classified advertisement in *Michigan Medicine* is 15¢ per word, with a minimum charge of \$7.50. Copy for classified advertisements should be received not later than the first of the month preceding the month of publication.

Positions open

Private Practices for General Practitioners, Internists and Ob/Gyn sponsored by teaching hospital in Illinois. Paid interviews, guaranteed come. Relocation. Special arrangement for rent and equipment. No fees. Will assist with state license. Resume-Professional Referrals, 7-14 Queens Blvd., Forest Hills, NY, 11375 or call 24 hours (212) 263-0400.

Wanted — Full-time Staff Physician for 350-bed accredited hospital providing rehabilitation, psychiatric and chronic disease services. General practice or internal medicine training and experience beneficial. Successful candidate must have Michigan license. Excellent salary and fringe benefits. Submit qualifications to: Personnel Director, Saginaw Community Hospital, 3340 Hospital Road, Saginaw, Michigan 48605.

Two Physicians Needed for Munising, Michigan. Rural community, gateway to Pictured Rocks National Park. Modern 40 bed hospital, U, computerized nuclear scanner, office space and hospital located next to Lake Superior. New school system, excellent summer and winter sports. Great place to raise a family. Three physicians already in the area, stable economic base. Contact Robert Hamilton, EVP, Munising Memorial Hospital, Sand Point Road, Munising, Michigan 49862.

Experienced General Surgeon needed to join two general internists, a gastroenterologist, three family practitioners and a pediatrician in busy satellite of the Marshfield Clinic at Dysmith, Wisconsin. Send Curriculum vitae to Sidney E. Johnson, MD, Medical Director, Marshfield Clinic, 1000 North Oak Ave., Marshfield, WI 54449, or call collect at (715) 387-553.

Urologist under 40 years of age. Board certified or board eligible with expertise in EMG, G and CT scan to join a young neurologist Southwest Michigan on the coast of Lake Michigan. Send replies to West Michigan Urological Associates, 1675 Leahy Street, Suite 328, Muskegon, MI 49442 or call (616) 65-4802.

Three Year Approved Psychiatric Residency Program now appointing for an immediate unexpected opening and for July, 1980. Small intensive psychiatric hospital, JCAH approved, affiliated with University of Iowa Medical College. Comprehensive program including two adult psychiatric units, adolescent unit, children's unit, alcohol & drug abuse unit, with innovative community liaison, and OPD. Eclectic approach. Situated in picturesque northeast Iowa near large cities with cultural advantages, set in rural setting. Ideal for family living. No financial sacrifice while learning. Top salary: first year \$24,669, second year \$25,854, third year \$27,123; liberal fringe benefits; some housing available. Opportunity to join staff on completion of training. All applicants must have completed one year in an approved

training program in internal medicine, family practice, or pediatrics or a flexible one year program, including four months in internal medicine. Write or call R. M. Akbar, MD, Acting Superintendent, or B. J. Dave, MD, Director of Education, Mental Health Institute, Independence, Iowa 50644. An Equal Opportunity Employer.

General Practitioner — to provide medical care in a small state facility for the mentally retarded, located in a rural setting in Michigan's beautiful Upper Peninsula. Current salary \$49,882 plus a liberal Civil Service fringe benefit package. Limited housing available at moderate cost. Write Steven A. Myers, MD, Chief of Clinical Affairs, Newberry Regional Mental Health Center, Newberry, Michigan 49868.

Family Practitioner — Tampa Bay Area — Florida. Federally qualified HMO is recruiting family practitioners for ambulatory care facilities in Clearwater, Florida. Competitive salary and comprehensive benefit program with opportunity to participate in academic program available. If team interaction and casual living appeal to you, send CV to: Prepaid Health Care, Inc., ATT: Jerry Williamson, MD, 1417 South Belcher Road, Clearwater, Florida 33516. (813)-535-3474.

Internist — Tampa Bay Area — Florida. Prepaid Health Care, Inc., a federally qualified HMO, is recruiting internists, BE or BC, for adult ambulatory care units in Clearwater and St. Petersburg. Excellent salary and benefit programs, with opportunity to participate in academic program available. Progressive, growing community. If interested in growing with us, send CV to Jerry Williamson, MD, Medical Director, 1417 South Belcher Road, Clearwater, Florida 33516. (813)-535-3474.

Positions With The State Of Michigan — Currently taking applications for positions expected to be available in the future. Primarily interested in board certified or board eligible internists with cardiology background. Office locations in Southfield, Lansing, and Traverse City. Also considering an office in Kalamazoo. Salary in 50's with approximately 23% fringe benefits. An equal opportunity employer. All enquiries treated confidentially. For further details please write: Disability Determination Service, P.O. Box 30011, Lansing, MI 48909, or call collect: Harry D. Nesmith, MD, Chief Medical Consultant (517) 373-7830. In Michigan, call toll free 1-800-292-2710.

General Surgeon — North Carolina. Needed for University owned hospital in small coastal town. This private practice opportunity is ideal for an experienced General Surgeon who would enjoy a relaxed, productive life style in a desirable climate on the coast. Send CV to MSMS, Box 20, 120 W. Saginaw, East Lansing, MI 48823.

Part-Time Physician Needed to do routine physicals to assess donor suitability for plasmapheresis. Good job for older physician looking to slow down. Malpractice coverage provided. Contact Doug Klynstra or Debra White at American Plasma Management, East Lansing. Phone 517-351-2620.

Internist with interest in cardiology, to join long established practice in rural community within 30 miles of large shopping areas. Active coronary care unit, excellent hospital and office facilities. Opportunity to become rapidly established in a busy practice with no investment. All Corporation fringes. Please call Area Code 517-846-6122 days or 846-4620 evenings, or write Malcolm K. Dolbee, MD, P.C., P.O. Box 609, Standish, Michigan 48658.

Thinking Of Retiring? Any age physician, medical directorships available across the USA. List valid licenses, when able to relocate. Salary \$30,000.00 per year, 35 hours per week,

malpractice insurance paid. If physician is not retired and desires a new practice opportunity, please send curriculum vitae, site location, salary, date able to relocate. Write: Fred Hrachovina, DO, 1000 Second Ave., South Minneapolis, Minnesota 55403 or call: 612-332-7938.

Family Practitioners: To expand central core of primary care physicians in well established southeastern Wisconsin multi-specialty clinic. 30 miles from Milwaukee. Excellent recreation area \$45,000 first year salary, with additional incentive plan and many other fringe benefits. Excellent opportunity. Send CV to Recruitment Committee, Burlington Clinic, S.C., Box 40, Burlington, WI 53105.

Urologist Position available at progressive VA Medical Center located in Michigan's upper peninsula. Board certified candidates are preferred. The community offers ideal family living in town of 18,000 people with good schools, year-round sportman's area with excellent hunting, fishing and winter sports. Well equipped 214-bed GM&S medical center offering competitive salary and benefits. Applicants must meet required spoken and written English proficiency. Write: Chief of Staff, VA Medical Center, Iron Mountain, MI 49801 or call: (906) 774-3300, Ext. 227. Allowable moving expenses paid. Equal opportunity employer.

Emergency Medicine Positions: available with Emergency Physician Group throughout Michigan, PA, NY, NJ, and Southeastern U.S. including all suburban, rural and metropolitan areas. Fee-for-services with minimum guarantee provided. Malpractice paid. Practice credits toward board certification. Please send resume to: NEEMA Emergency Medical, Ste. 400, 399 Market St., Philadelphia, PA 19106. In Pennsylvania, call 215-925-3511, those outside Pennsylvania call 1-800-523-0776.

Miscellaneous

Contemporary Medical Office — For October, 1980 occupancy on John R., between 11 and 12 mile roads Madison Heights. Tremendous growth area. Excellent opportunity for MD or DO medical physician. Up to 2,000 sq. ft. available. You can design your own office. Call Doctor S. J. Goldstein for additional information, 313/399-4905, 313/499-4370, 313/399-4691.

Lake Property In Caseville. 10 acres, 360 foot frontage, \$100,000. Evenings 313-769-1123.

Sanibel Island, Fla. Luxurious 2 bedroom, 2 bath condominiums on Gulf. Completely furnished including linens. Miles of uncrowded white sand beaches, fringed by lush tropical foliage, wild flowers, graceful sea oats and flowering trees. All amenities including pool, tennis, golfing, fishing, boating, sailing, bicycling and bird watching. Weekly, monthly discount. 313-645-5498.

Traverse City Michigan — Plenty of glass, magnificent modern 4 bedroom, 3 bathrooms, 2 fireplace home, living room, dining room, family room overlooking Lake Leelanau on Timberlee ski resort. Weekly or monthly, open December thru April. Call Cindy Thompson 313-882-7060 or write 16840 E. Warren, Detroit, MI 48224.

Medical And Dental Office under construction — 1000 sq. ft. suite available — 4147 Sixteen Mile Road, 2 blocks east of Ryan, Sterling Heights. Call B. Monast at 313/542-7100.



PRESIDENT'S PAGE

Medical arbitration statute — either amend it or repeal it

By Ernest P. Griffin, Jr., MD, MSMS President

The present medical malpractice arbitration statute as an option to the court system is a luxury the public, hospitals and physicians no longer can afford.

The statute has been in effect since January, 1976.

In November, 1979 the prestigious firm of Arthur Young and Company said the arbitration system had not processed enough cases for the results to be statistically significant. The company is of the opinion that at the present rate of case closures it will be July, 1983 before they can make a determination. The presently available data indicate this delay is not acceptable.

A brief review of the past four years is in order. In the climate of the malpractice crisis of 1974 we were told that the arbitration system would be the physicians' salvation.

Promises unmet

The promises were for a panacea. The new system would shorten the time interval between the alleged malpractice event and the settlement date. Attorneys' fees would be eliminated or greatly reduced. The backlog of cases would be non-existent. The settlements would be more realistic. There may never be enough settled cases to evaluate the statement concerning settlements but the other promises are simply not true.

What has really happened as a result of the enactment of the

statute? We can clearly enumerate some of the problems.

The system generates lawsuits concerning whether the arbitration agreement is or is not valid. The result is either two lawsuits or one lawsuit and one arbitration action.

The system provides that patients have 60 days after completion of treatment to elect if they wish to remain in arbitration. Many cases are excluded from the arbitration system by this rule. Take the case of the patient that signs an agreement and enters the hospital and suffers an event that results in death or a brain-damaged incompetent person. All of these cases remain in the court system since they are excluded by the 60-day rule.

Or, take the pregnancy case. Cases are in litigation over the rights of the unborn child. Here we have the following possibilities: a mother in arbitration, the child in court, and the physician in both arbitration and the court.

The laundry list of defects goes on and on but the point is that the defense attorneys' charges run on and on and it is our insurance premium dollars that pay this bill.

These preliminary statements are only to get us to the all-important bottom line in these days of cost containment. The most significant finding is that the arbitration system has increased the cost of medical care and has done little or nothing to

alleviate the malpractice situation.

The actual cost is astronomical, and patients and physicians are being unduly burdened. This cost feature was not addressed at the time of the enactment of the statute. It is impossible to estimate the cost of the additional litigation that has been generated but our premium dollars are paying the defense costs.

Results no bargain

Our professional liability insurance companies have paid \$450,000 into the arbitration fund in the first three years. It has been estimated that the average cost to print, distribute and process the arbitration material at the hospital level is \$16,473 per hospital per year. If 50 percent of the 216 Michigan hospitals participate, then the bill is \$1,775,000. The cost of the required evaluation is unknown but collecting the material and issuing a 150-page brochure is not cheap.

What have we received for our money? The total number of filed cases is 182. Only 14 cases have been settled by the arbitration system. These results are certainly no bargain.

If a superficial perusal of the system can elicit these problems then the arbitration statute must be amended or repealed.

ROCHE

For recurrent attacks of urinary tract infection in women

Bactrim™ DS Double Strength Tablets

Each tablet contains 160 mg trimethoprim and 800 mg sulfamethoxazole.



Just one tablet b.i.d. for 10 to 14 days

- Action at urinary/vaginal/lower bowel sites helps eliminate reservoirs of infecting organisms
- Distinctive antibacterial action plus wide spectrum helps eradicate recurrent UTI
- Low incidence of bacterial resistance in community practice

- Convenient *b.i.d.* dosage provides day-and-night antibacterial control
- Contraindicated during pregnancy and the nursing period. During therapy, maintain adequate fluid intake; perform CBC's and urinalyses with microscopic examination.

Before prescribing, please consult complete product information, a summary of which follows:

Indications and Usage: For the treatment of urinary tract infections due to susceptible strains of the following organisms: *Escherichia coli*, *Klebsiella-Enterobacter*, *Proteus mirabilis*, *Proteus vulgaris*, *Proteus morganii*. It is recommended that initial episodes of uncomplicated urinary tract infections be treated with a single effective antibacterial agent rather than the combination. Note: The increasing frequency of resistant organisms limits the usefulness of all antibacterials, especially in these urinary tract infections.

Also for the treatment of documented *Pneumocystis carinii* pneumonitis. To date, this drug has been tested only in patients 9 months to 16 years of age who were immunosuppressed by cancer therapy.

The recommended quantitative disc susceptibility method (*Federal Register*, 37:20527-20529, 1972) may be used to estimate bacterial susceptibility to Bactrim. A laboratory report of "Susceptible to trimethoprim-sulfamethoxazole" indicates an infection likely to respond to Bactrim therapy. If infection is confined to the urine, "Intermediate susceptibility" also indicates a likely response. "Resistant" indicates that response is unlikely.

Contraindications: Hypersensitivity to trimethoprim or sulfonamides; pregnancy; nursing mothers; infants less than two months of age.

Warnings: Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia with purpura in elderly patients on certain diuretics, primarily thiazides. Sore throat, fever, pallor, purpura or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended; therapy should be discontinued if a significantly reduced count of any formed blood element is noted.

Precautions: Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function.

Adverse Reactions: All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. **Blood dyscrasias:** Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. **Allergic reactions:** Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. **Gastrointestinal reactions:** Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea and pancreatitis. **CNS reactions:** Headache,

peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. **Miscellaneous reactions:** Drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L. E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.

Dosage: Not recommended for infants less than two months of age.

Urinary Tract Infections: Usual adult dosage—1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 10-14 days.

Recommended dosage for children—8 mg/kg trimethoprim and 40 mg/kg sulfamethoxazole per 24 hours, in two divided doses for 10 days. A guide follows:

Children two months of age or older

Weight		Dose—every 12 hours	
lbs	kgs	Teaspoonfuls	Tablets
20	9	1 teasp. (5 ml)	½ tablet
40	18	2 teasp. (10 ml)	1 tablet
60	27	3 teasp. (15 ml)	1½ tablets
80	36	4 teasp. (20 ml)	2 tablets or 1 DS tablet

For patients with renal impairment:

Creatinine Clearance (ml/min)	Recommended Dosage Regimen
Above 30	Usual standard regimen
15-30	½ the usual regimen
Below 15	Use not recommended

***Pneumocystis carinii* pneumonitis:** Recommended dosage: 20 mg/kg trimethoprim and 100 mg/kg sulfamethoxazole per 24 hours in equal doses every 6 hours for 14 days. See complete product information for suggested children's dosage table.

Supplied: Double Strength (DS) tablets, each containing 160 mg trimethoprim and 800 mg sulfamethoxazole, bottles of 100; Tel-E-Dose® packages of 100. Tablets, each containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 40, available singly and in trays of 10. Oral suspension, containing in each teaspoonful (5 ml) the equivalent of 40 mg trimethoprim and 200 mg sulfamethoxazole, fruit-licorice flavored—bottles of 16 oz (1 pint).



Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

Please see back cover.

Her next attack

the BactrimTM 3-system counterattack



ROCHE

Bactrim has shown high clinical effectiveness in recurrent cystitis as a result of its wide spectrum and distinctive antimicrobial action in the urinary, vaginal and lower intestinal tracts.

The probability of recurrent urinary tract infection appears to be enhanced by the establishment of large numbers of *E. coli* or other urinary pathogens on the vaginal introitus. The trimethoprim component of

Bactrim diffuses into vaginal fluid in effective concentrations, thus combating migration of pathogens into the urethra.

Studies have shown that Bactrim acts against *Enterobacteriaceae* in the bowel without the emergence of resistant organisms. Thus, Bactrim reduces the risk of introital colonization by fecal uropathogens. It has *no* significant effect on other normal, necessary intestinal flora.

Bactrim fights uropathogens in the urinary tract/vaginal tract/lower intestinal tract

Please see reverse side for summary of product information.

JUN 13 1980

MICHIGAN MEDICINE

Vol. 79, No. 15
May 23, 1980

Breaking News for Michigan Doctors

CAPSULES

THE MICHIGAN BOARD OF MEDICINE has received numerous complaints that medical work excuses are being issued in instances where the physician has not treated or seen the individual to whom the excuse is issued. The issuance of fictitious medical excuses for a disability or as an excuse for time lost from work is contrary to acceptable and prevailing medical practice. If the charge is substantiated, the writing of fictitious work excuses, even without charge, would constitute a violation of the Public Health Code, 1978 PA 368, as amended; MCLA 333.1101 et seq; MSA 14.15 (1101) et seq. and could result in the revocation of that physician's license.

THE TWO-DAY annual Gull Lake Conference of the MSMS Committee on Maternal and Perinatal Health is scheduled May 29-30 at the MSU Gull Lake Conference Center at Hickory Corners near Kalamazoo. Eight hours of Category I CME credit will be awarded to the physicians attending the conference, which will feature sessions on abortion, birthing alternatives and midwifery. Lee B. Stevenson, MD, Detroit, is committee and conference chairman, while Katie Brewbaker, MSMS staff, is handling arrangements.

CORRECTION: The MSMS China Adventure group travel tour is scheduled Sept. 10 to 29, rather than Sept. 19 to 29, as previously announced in Medigram.

MEDIGRAM

MSMS working with State to modify second opinion program

Representatives of the MSMS Medicaid Liaison Committee and the state Medical Services Administration have discussed MSMS legislative efforts to repeal the state's Medicaid second surgical opinion program. The two groups' representatives met May 20 at the request of the MSA to discuss the MSMS House of Delegates' recent resolutions addressing issues of improper restriction of indicated surgical procedures. From the MSMS Committee were David Siegel, MD, chairman and Gerald Mandell, MD. A tentative consensus for policy change in the near future was reached on the following issues: meniscectomy documented by arthroscopy will not require approval or second opinion; cholecystectomy documented by gallstones will not require a second opinion; cystoscopy will not stay on the mandatory second opinions list. In addition, the recent modification to exclude a second opinion on herniorrhaphy for patients five years and under was reinforced. The Medicaid Liaison Committee will receive a progress report on the implementation date of the changes at its next meeting July 1.

Brown McNeely Fund up for bids

The Brown-McNeely Fund presently is reviewing proposals from seven insurance companies which have committed to purchasing or assuming the assets and liabilities of the Fund.

Barring a last minute legislative extension, the Fund cannot issue or renew a policy of insurance which extends beyond July 1, 1980.

Proposals to assume the Brown-McNeely Fund operations range from continuing insurance services for present Brown-McNeely Fund policyholders by the purchasing company to continuing the claims functions only, for the losses incurred since the Fund's inception. The Brown-McNeely Fund Board of Directors is meeting on May 23 to decide on the most acceptable proposal.

OVER 1,000,000 telephone calls have been received to date by the Tel-Med system sponsored in the Detroit area by the Wayne County Medical Society and Blue Cross Blue Shield of Michigan. That is the largest number of calls handled by any of the Tel-Med systems across the country. Tel-Med, housed in the WCMS headquarters building, has been averaging 25,500 calls per month, according to Roger Mecum, WCMS director. He expects a new Reye's Syndrome tape to add to the volume. The Wayne system has 330 tapes available.

KALAMAZOO PHYSICIANS interviewed following the touchdown of two tornados May 13 in and near their city were pleased with the effectiveness of medical personnel and their hospitals' disaster plans. "We thought we had a good plan. Now we know it," said Robert A. Janke, MD, chief of staff at Bronson Hospital. The hospital, just one block from the main path of the tornado which destroyed the downtown, handled over 65 emergency patients in the hour or two following the tornado, while nearby Borgess handled approximately 15.

Joint legislative committee works to stop CHPC debed plan

At its May 19 meeting, the Special Joint Committee on Bed Reduction moved to amend legislation for a moratorium on the hospital bed reduction plan for CHPC-SEM (Southeast Michigan). MSMS was represented at the Special Joint Committee by Kenneth J. Ray, MD (Trenton), chairman of the MSMS Steering Committee on Health Planning.

The proposed amendment, which will be introduced in both Houses of the Legislatures states the proposed CHPC plan is not considered to meet the bed reduction laws' requirements. It would relax the current certificate of need moratorium so that projects that are "not inconsistent with the goal of hospital bed reduction" can be approved. The net effect of this amendment is to abolish the current CHPC plan and maintain the status quo until another plan is developed. The action of the Special Joint Committee is consistent with the March 5 action of the MSMS Council which called for a moratorium until such time as the problem in the CHPC plan could be worked out.

The importance of a moratorium is that it provides breathing space in the struggle against the CHPC bed reduction plan. Now the major challenge is to restructure the CHPC bed reduction plan into a more equitable vehicle.

HB 4555 in Senate committee

The Senate Commerce Committee this week set aside its work on cost containment portions of HB4555, and began work on other sections designed to reform the functioning of the health care third party payor. Limits on reserves and on things the company can do occupied the committee while it was arranging for an independent economist to study and report on Section 5. An early report to the Senate floor on the legislation seems unlikely.

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Editor: Judith Marr

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JUN 23 1980

MICHIGAN MEDICINE

Vol. 79, No. 16
June 13, 1980

Breaking News for Michigan Doctors

MEDIGRAM

CAPSULES

THE BROWN-MCNEELY FUND board of directors was to make its final decision June 13 on insurance companies' bids to assume the fund's assets and liabilities. The Michigan Physicians Mutual Liability Company is among the seven insurance companies bidding.

THE U.S. LABOR DEPARTMENT plans to put into effect Aug. 21 a new regulation allowing workers to obtain their on-the-job medical records, including details of their exposure to dangerous substances. The new rule also requires employers to furnish the records to unions if the workers consent.

Currents and eddies

John R. Ylvisaker, MD MSMS President

Board of Medicine--There is substantial concern for the near-term status of the board. Organizational and operational changes of the Department of Licensing and Regulation, coupled with the resignation of the board's executive director, Bert Brennan (Mr. Brennan announced his retirement from the board June 4, effective July 5), pose a real threat to the board's effectiveness. MSMS Board of Medicine Liaison Committee Chairman Charles L. Seifert, MD; MSMS Council Chairman Louis R. Zako, MD, and I are actively involved in seeking solutions to the problems.

MSMS members called to resist HB 4555 amendment

President John R. Ylvisaker, MD, has called on every MSMS member to seek removal of a Senate amendment to HB 4555 that would establish a one percent per year reduction in Blue Cross Blue Shield payments to providers to deflate the health economy. The brittle, fixed cost deflater, in an unpredictable state economy, removes flexibility and makes intervention by the insurance commissioner more likely; hence rate regulations, Doctor Ylvisaker told the membership. He urged members to contact their state senators to support another amendment on the Senate floor that would reverse the cost deflater and support quality cost containment programs.

HB 4555 was reported out of the Senate Commerce Committee last week with the deflater amendment. A version already has passed the House. Full Senate action is expected daily. Then the bill probably will go to a Senate-House conference.

MSMS reluctantly supported the House version because it approaches cost containment with a formula taking into consideration inflation, the consumer price index and base year aggregate payments to provider classes. It further calls for providers' consultation and advice in establishing cost containment plans, with the provision that the insurance commissioner be authorized to enter into cost containment planning only when that fails. The House version is referred to as the "private sector" bill. The addition of the one percent per year rollback introduces a further rigid requirement that makes rate regulation by the insurance commissioner much more likely.

Among other changes in the Senate version:

One nurse was added to the provider contingent on the BCBSM board, bringing to eight the number of provider classes on the board of 35 members.

Public appointees to the board by the Governor were increased to four, two of whom must be more than 62 years old. Roll call votes by the board are mandated when called for by three or more members.

Unfortunately, the entire bill is not satisfactory because of its regulatory approach. Without the deflater, however, it does seem to represent a middle-of-the-road compromise.

THE MEDICAL-LEGAL PROJECT GROUP of the Michigan Council of Deans is seeking examples of medical-legal problems and questions encountered by Michigan physicians in their practices. The examples will be used to help compile an exhaustive legal reference manual for Michigan physicians. Questions will be considered and answered in the writing of the text, which is in the draft stage. The text is tentatively called "The Law of Medical Practice in Michigan." Physicians with examples should submit them to the project at 527 E. Liberty St., Suite 205, Ann Arbor, 48109.

TWO MICHIGAN MEN presented perspectives on Michigan's hospital bed reduction situation at the annual meeting of the American Health Planning Association June 1-4 in San Francisco. They were Jay Endsley, director, Michigan Office of Health and Medical Affairs, and Dennis Paradis, director, MSMS Physician/HSA Support Center. Mr. Paradis' topic was "Medicine's Response to Regulatory Initiatives," while Mr. Endsley presented the health planner's perspective.

FTC vs. MSMS trial underway

The government has introduced dozens of documents in the opening days of the FTC vs. MSMS case in Washington, DC, reports MSMS Legal Counsel A. Stewart Kerr. The Federal Trade Commission has called three witnesses as of this writing: Louis F. Hayes, MD, just retired as Blue Cross Blue Shield of Michigan vice president for professional affairs; Melvin Glasser, United Auto Workers director, Social Security Department, and Robert Reveley, BCBSM vice president, Auto and National Marketing Group. Mr. Kerr expects the government's testimony in Washington to be completed by June 16 or 17. MSMS is to present its side of the case beginning Sept. 22. The FTC vs. MSMS trial began June 4 rather than June 2, as scheduled, as it was held up while the FTC awaited federal appropriations to permit it to continue to function.

Higher interest ahead on litigation

On May 15, the legislature passed SB 324, which is now being processed for signature by the Governor. The new statute provides that the rate of interest upon a judgment and pertaining to all pending litigation will be 12 percent compounded interest. The previous statute provided six percent simple interest. For example, a five-year-old case resulting in a judgment would be multiplied by 130 percent under the old statute, but under the new statute the multiplier would be 176 percent. This significant change could affect a litigant's opinion as to whether to sue or, having filed suit, whether to settle.

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East Lansing, Michigan 48823

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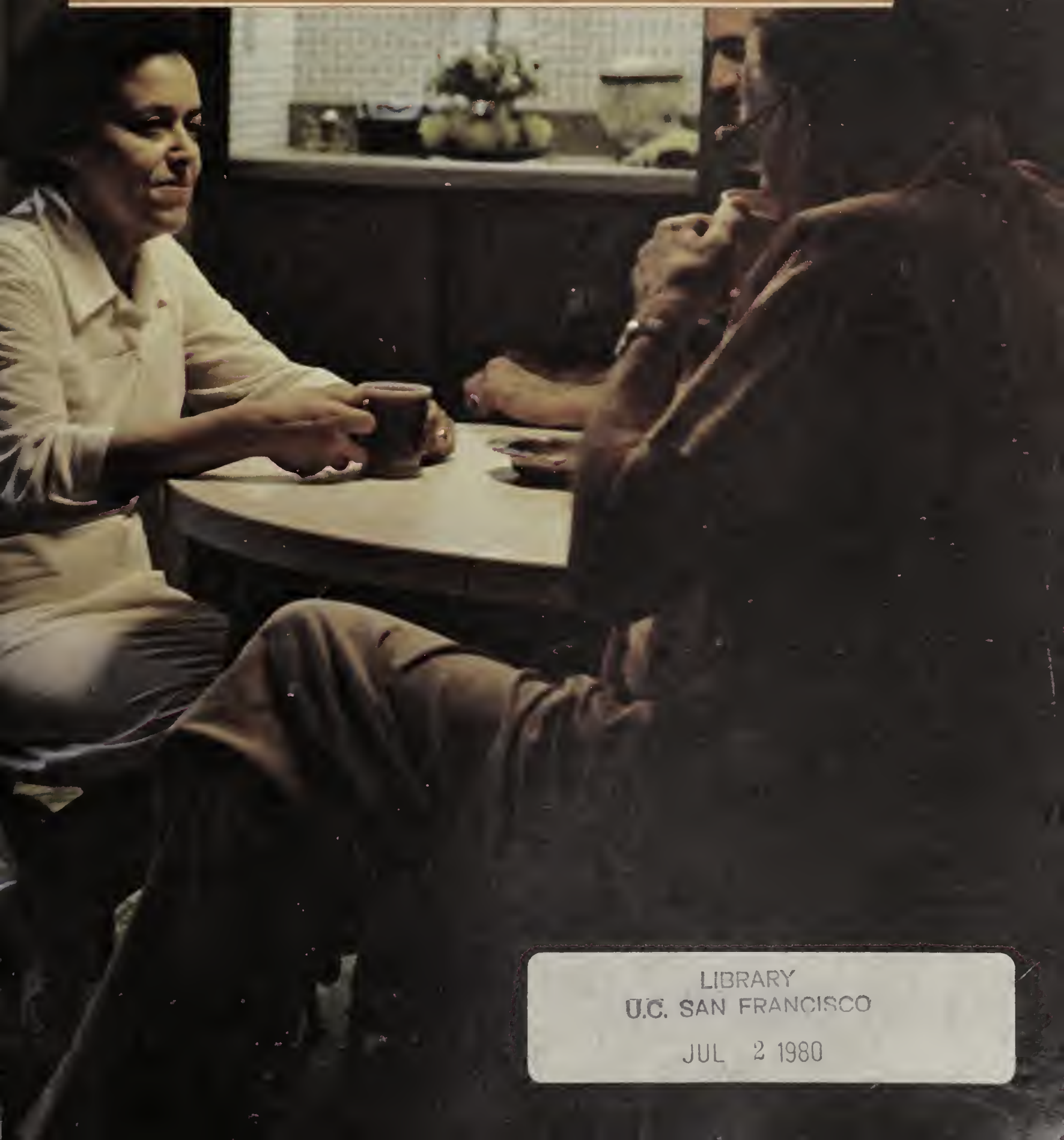
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June 1980

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Vol. 79 No. 17



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Quiet times with the family are part of the health professional's role in the hospice, a developing form of medical care endorsed and supported by MSMS. Michigan hospices are the subject of the special report beginning on page 291 of this issue. (Photo by Rod French)

MICHIGAN MEDICINE

June 1980, Volume 79, Number 17

Special report

- 291** The hospice movement in Michigan is described in this issue, with articles on legislative action, a moving account of what one hospice contributes to its community, a roundup of the several hospices' activities around the state, and a summary of MSMS and Wayne County Medical Society official actions; Rep. David Hollister, Rod French, Kevin A. Kelly

Features

- 298** New Michigan data on physicians' numbers, location, specialties
- 312** Photos of 1980 MSMS House of Delegates
- 314** Warren F. Tryloff honored
- 317** Maternal Health Desk Reference Card No. 24; Ultrasound
- 319** 1980 Michigan Reye's Syndrome report; Martha Smith
- 322** MSMS Sports Medicine Conference emphasizes female athletes' abilities
- 324** 1980 MSMS Annual Scientific Meeting previewed
- 326** Detroit Medical Society strives to bring best health care to all; Shelton Reece
- 336** MSMS/A Legislative Day in photos
- 338** U-M researchers seeking patients

Departments

- 288** In my opinion; Vickers C. Hansen, MD
- 289** Letters
- 307** Meetings
- 310** MSMS Q/A
- 330** Peer review exchange; Daniel J. Fall, MD
- 331** Medico-legal
- 333** Disciplinary actions, Board of Medicine
- 335** Health planning update
- 343** News
- 344** Category I courses
- 346** New members
- 348** Deaths
- 348** Classified
- 349** Ad index
- 350** President's page; John R. Ylvisaker, MD

Try a political candidacy; it's time well spent

By Vickers C. Hansen, MD, Manistee



This year the media is filled with news of political activity. At this time it is primarily of candidates and issues at the national level. The theme is informative, and the goal is participation, whether it be by support, contributions, or votes.

We understand the importance of participation. That is how our country works. We have been responsive and interested. Certainly the issues are as vital as at any time in memory.

A common complaint heard repeatedly is the lack of attractive choices. This is true both with issues and perhaps even more with candidates. Many wish the selection were better.

At the local level, there may not even be candidates. Too few wish to be involved. There are enough aggravation and demands on time already. Politics is not now, and perhaps never was, held in the highest esteem.

Historically, our profession has been involved, and in the past, to a greater degree than today. There were many reasons for that involvement, intellectual, emotional, and economic.

For those who have never thought of it, I would like to suggest serious consideration of candidacy. At least at the local level, the demands are not incompatible with medical practice, at least not for those with interest. There is no question political action takes time, but the time is well spent. It is certainly as important as time spent in most other outside activities.

There are many qualifications, including interest, concern, and a willingness to become involved. There are many possibilities to consider. Some of these might include the local school board, the city council, or county government. The strength of these groups depends on the people who participate. The diversity of backgrounds brings fresh ideas to problem solving and implementation of goals.

Political involvement is of beneficial experience to those who participate also. It provides a unique opportunity to work with others from very different backgrounds. The insights gained can be of value, both in understanding the way things are today, and how to influence them tomorrow.

In many cases the time for filing petitions and getting on the primary ballot is at hand. All too often these deadlines are buried inconspicuously with the legal notices. If you think you might be interested, it's time to start. There is no better time than the present.

Try it, you might like it.

Doctor Hansen is mayor of the city of Manistee.

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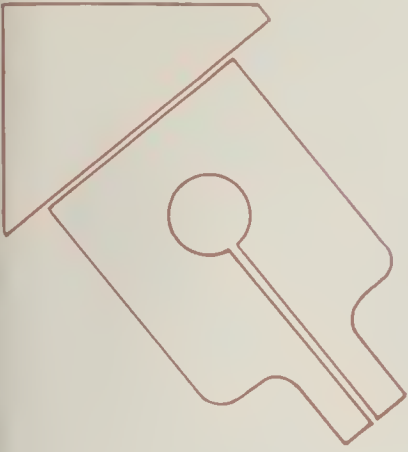
Michigan Medicine, the official journal of the Michigan State Society, is dedicated to provide useful information for Michigan physicians about actions of the Michigan State Medical Society and contemporary issues, with special emphasis on socio-economics, legislation and news about medicine in Michigan. Major medical developments will be reported and interpreted as has been the custom.

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L and R director challenges recent MM article

Your recent article entitled "Board of Medicine asking L and R for clear statement to end strife and tension" (April 1980 *Michigan Medicine*) has many redeeming features. It does represent a noteworthy attempt to describe to your readers the work of the Board of Medicine, the Department of Licensing and Regulation, and the relevant requirements of the Public Health Code.

I assume, however, that the statements of Board Chairman Don Kuiper may more accurately be attributed to the article's author than to Doctor Kuiper himself. Doctor Kuiper knows full well that this Department fully concurs with the division of labor which allows the Board to be the policy makers and the staff the implementers of those policies. Actually, the Department has pushed for such a division for at least as long as I've been Department Director, but we've often met with resistance from Board members who contended they should be intimately involved in every aspect of the administrative work of the Board.

Doctor Kuiper's alleged characterization of the Department as having "usurped some of the Board's investigative functions" is a puzzler to me. In fact, the Public Health Code itself transfers some of the investigative functions from the Board to the Department in order to maximize the

chances that consumer complaints will receive a fair handling. Of course it is difficult for the Board to give up some of its time-honored practices, but this is what the law requires.

A recent *Detroit Free Press* poll indicated that 88 percent of the respondents do not believe that doctors have either the will or the ability to discipline their fellow practitioners.

Putting this responsibility into the hands of the Department, adding public members to the Board, and establishing sanctions for specific violations of the Public Health Code are attempts to remedy this lack of confidence by the public.

We all know that newspaper and magazine headlines often distort the real substance of the body of a story. Sadly, that's the best explanation I can come up with for the somewhat gratuitous and inflammatory title of your article. I fear the same is true for the paraphrase in the table of contents.

Sincerely,

William S. Ballenger, Director
Michigan Department
of Licensing and Regulation

Editor's note: *Michigan Medicine* stands by the accuracy of the article and the sentiments expressed in it. We invite members of the Board of Medicine and physicians who have dealings with the Board to respond to the original article, and to Mr. Ballenger's comments above.

Addendum: Public members of the Board of Medicine, inadvertently omitted from the original article, are Margaret Thoms, Birmingham; Sondra Shaw, Traverse City; Karen Kotch, West Bloomfield, and James Dresbach, Taylor.

MM article receives national recognition

I am pleased to inform you that Wilah Weddon has received a second place Federation of Press Women award for an article, "New state mental health director to seek higher morale," printed in your publication, *Michigan Medicine*.

This is a national honor. The article had won first place in Michigan competition and now will be honored during the convention of National Federation of Press Women in Des Moines, Iowa, June 19-21.

This is a high honor and your publication also will receive recognition.

Sincerely,

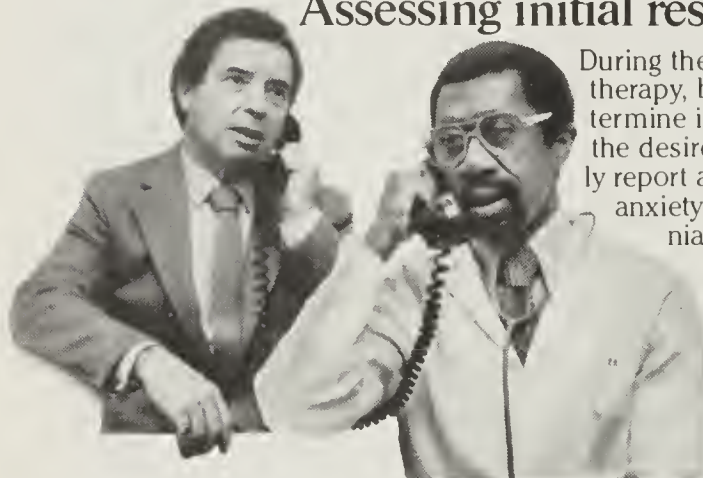
Carol Ankney
Awards Chairman
Michigan Women's Press Club

Looking for MDs?

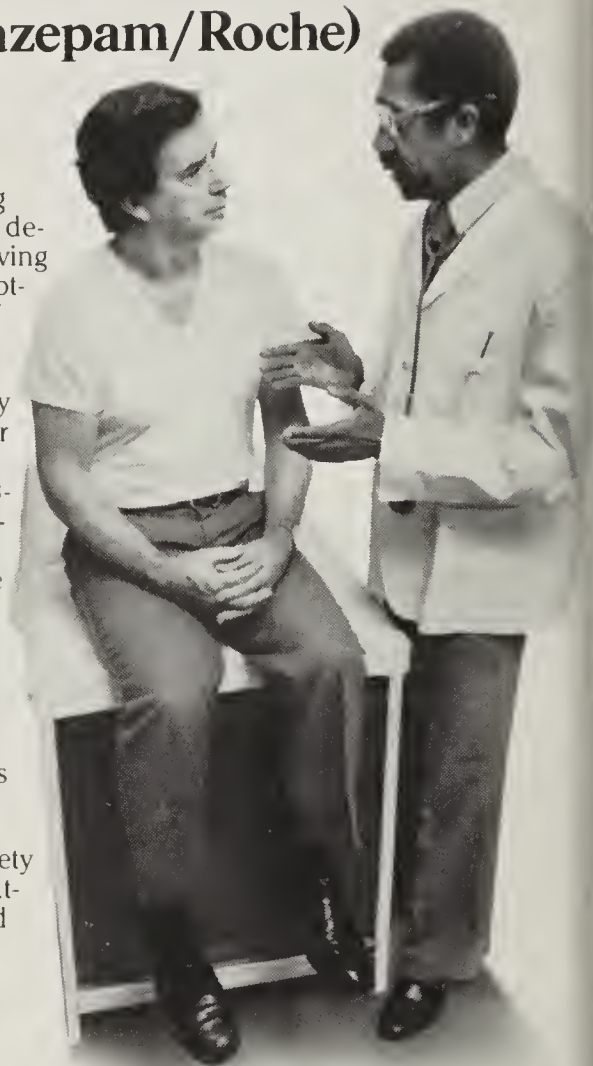
Any physician, hospital, community committee interested in recruiting one or more physicians can register their needs with the Physician Placement Service of the Michigan Health Council, 1407 S. Harrison Rd., East Lansing, Mi. The Council has 506 physicians registered as being interested in possible practice opportunities in Michigan. The executive of the MHC is Herbert A. Auer, former deputy director of the Michigan State Medical Society.

Monitoring patient response to Valium® (diazepam/Roche)

Assessing initial response to therapy



During the first follow-up visit after initiating therapy, both physician and patient should determine if Valium (diazepam/Roche) is having the desired effect. Most patients will promptly report a feeling of relaxation and relief of anxiety-linked symptoms such as insomnia, headaches, palpitations and hyperventilation. You will probably observe that the patient is calmer and more relaxed. If, however, patient response does not measure up to expectations, a reevaluation of the patient's profile with modification of the dosage regimen should be considered.



Making dosage adjustments

START	ADJUST
2 mg to 10 mg 2x to 4x daily	↑ ↓

With any psychoactive medication it is good medical practice to initiate therapy at base dosage levels and titrate to the patient's needs. With Valium, experience has shown that 5 mg t.i.d. is usually sufficient although some patients with severe or persistent anxiety may require higher dosages initially. In geriatric or debilitated patients, the recommended dosage is 2 to 2½ mg once or twice daily.

When anxiety fluctuates, as is common with most patients, the dosage may be adjusted as needed during the course of therapy; three strengths in scored tablets give you unmatched flexibility and simplicity in individualizing dosage.

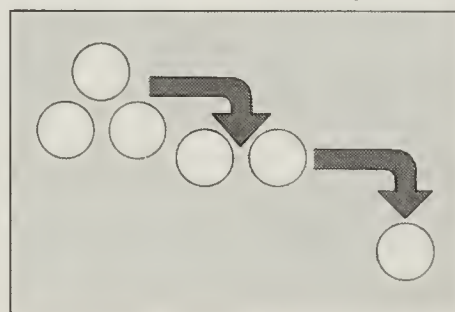
Evaluating progress toward therapeutic goals

SET GOALS						
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30	31		

At the beginning of therapy it is now common practice for both physician and patient to establish treatment goals and to estimate the amount of time needed to achieve them. Then the patient knows what to expect and when to expect it.

Some physicians find that compiling a checklist of presenting symptoms and complaints is useful for assessing the patient's response from visit to visit. In this way, progress toward attainment of the therapeutic goal is reviewed at regular intervals. As patients feel their symptoms abate and begin to develop insight into the sources of their anxiety and psychic tension, the checklist can be expected to dwindle.

Discontinuing pharmacologic intervention



When you decide to discontinue therapy, tapering dosage is good medical practice. Although rarely necessary after short-term treatment with Valium, gradual dosage reduction is advisable for patients who have been on extended therapy. This gradual discontinuance should preclude either

recurrence of pretreatment symptoms or development of untoward side effects. Symptoms of withdrawal have almost always been associated with abrupt discontinuance of therapy at higher dosages taken continuously over long periods of time.

2-mg, 5-mg, 10-mg scored tablets
Valium® ^{IV}
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An Important Adjunct to Your Treatment Program for Excessive Anxiety



See the following page for a summary of product information.

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Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety associated with anxiety disorders, transient situational disturbances and functional or organic disorders, psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation, symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal, adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy)

The effectiveness of Valium (diazepam/Roche) in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma, may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication, abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms similar to those with barbiturates and alcohol have been observed with abrupt discontinuation, usually limited to extended use and excessive doses. Infrequently, milder withdrawal symptoms have been reported following abrupt discontinuation of benzodiazepines after continuous use, generally at higher therapeutic levels, for at least several months. After extended therapy, gradually taper dosage. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

Use in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed, drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported, should these occur, discontinue drug. Isolated reports of neutropenia, jaundice, periodic blood counts and liver function tests advisable during long-term therapy.

Dosage: Individualize for maximum beneficial effect. **Adults:** Tension, anxiety and psychoneurotic states, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed, adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d., adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. **Geriatric or debilitated patients:** 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) **Children:** 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

Supplied: Valium® Tablets, 2 mg, 5 mg and 10 mg—bottles of 100 and 500, Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10, Prescription Paks of 50, available in trays of 10.



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SPECIAL REPORT

Outlook good for hospice legislation

By Rep. David C. Hollister

Americans generally have had a great deal of trouble coping with death. Our traditional response has been to hospitalize the patient with the goal of diagnosis and cure.

Yet, for the terminally ill, this may be an inappropriate response. The goal for the terminally ill ought to be to make the patient's last days as comfortable and meaningful as possible.

Hospice attempts to meet this goal.

With all the current interest in hospice care has come a need for legislation. HB 4909 was the result of a broadly based "Hospice Technical Work Group," which consisted of representatives from state agencies, hospice groups, medical associations including MSMS and other interested groups. Basically, HB 4909:

- Would define hospice in the public health code. This would recognize hospice as a legitimate health facility, and subject it to certificate of need.

- Would provide for licensure of hospice programs by the Michigan Department of Public Health. A hospice would be required to have a coordinated set of services to address the physical, psychological, social, and spiritual needs of the individual and family throughout the periods of illness and bereavement. Admission to a hospice program would be limited to individuals whose death is expected within six months. Licensure would also help to encourage and permit third party reimbursement.

The bill overwhelmingly passed the House of Representatives in March on a 98 to 1 vote. As of this writing, it is in the Senate Committee on Health and Social Services, chaired by Sen. Edward Pierce, MD, (D-Ann Arbor).

All of the interested groups have indicated support for this bill, and more importantly, support for providing hospice care as an available alternative. It also appears that hospice care may reduce health care costs — something which also has considerable legislative appeal.

Legislative reaction thus has been favorable. It now appears that HB 4909 will be reported by the Senate committee in mid-May, and could be on the Governor's desk by early June.

Mr. Hollister (D-Lansing) is sponsor of the hospice legislation.

The MSMS Council endorses the concept of hospice programs and has appropriated MSMS funds (\$500) to help support the Michigan Hospice Organization, which is working to educate Michigan citizens and to help form hospices around the state. On the next few pages, you will find a poignant hospice experience, a roundup of hospice activity and MSMS' official view.

Bay de Noc Hospice offers comfort

By Rod French, Special to Michigan Medicine



Bay de Noc nurse Vi DeGrand talks with Bryson family

ESCANABA — Peggy Bryson, an Escanaba Daily Press reporter, wrote in 1978 about a local hospice program that was just trying to get established.

With a touch of irony she recalled, several years later, "I knew about hospice as a journalist."

The involvement soon became more personal.

In September of 1979 Peggy Bryson found herself living her own story.

Her mother-in-law, Lucille Bryson, 62, was dying of cancer.

That slow realization came after a year of unsuccessful chemotherapy treatments. It rocked a closely-knit family.

The Bryson family has roots going back three generations in this Upper Peninsula community of 16,000. The family patriarch, Raymond Bryson, 67, is a retired factory worker, tall, broad-shouldered, with a strong face and greying hair. He and Lucille, his wife of 44 years, lived in a 100-year-old home once owned by Bryson's father. The couple's three children all married and settled in the Escanaba area.

As the cancer progressed, three generations of Brysons were determined to keep Lucille out of a hospital or nursing home.

But even their strong, extended family network was stretched to the breaking point.

Ray became almost a prisoner in his own house caring for his wife. The couple would sit together all night long when pain kept Lucille awake. The children visited almost around the clock.

"You can't believe the emotional drain," Peggy Bryson says softly.

"It was dreadful to sit and feel so helpless. To see Mom in pain and not be able to help.

"The second terrible thing was to see it destroying the husband who

loved her. He was nervous and wouldn't leave her side. He wouldn't eat."

Finally, Peggy Bryson suggested the family turn to Bay De Noc Hospice, Inc. The non-profit, home-based hospice program has been in operation only a few months. But it proved to be the lifeline the Bryson family needed.

Part of living

Hospice care focuses on alleviating the debilitating pain that often accompanies terminal cancer, on keeping patients in the home to the greatest extent possible, and on dealing with the emotional and psychological problems of the illness.

Paul Werner, MD, an Escanaba physician, is medical supervisor for Bay De Noc Hospice. He is frank and sometimes outspoken. Doctor Werner acknowledges that many of his colleagues are wary of the hospice concept. To some it smacks of giving up.

The opposite is true, Doctor Werner says.

"Hospice is coming to peace with the fact that death is a part of living," he says.

"Physicians have a hard time saying, 'The patient is dying. There is nothing I can do for him.' Most physicians are trained to treat with the expectation of recovery."

And, when everything fails, "there's a sense of futility — a sense 'There's nothing I've got left to offer and therefore I'm not needed here anymore,'" Doctor Werner says.

But, Doctor Werner stresses, there is a flip side to that coin. When medical technology can't cure, it can help make what's left of life worth living.

"I can help the patient die pain-free, physically sound and emotionally and spiritually intact. That is, in fact, a sort of success," he says.

Two-fold approach

The hospice team's approach is two-fold.

Doctor Werner supervises medical treatment, working with the patient's family physician — who remains the physician in charge of the case.

Pain control is the primary medical concern. The hospice uses a liquid morphine-elixir mixture.

Paradoxically, use of a heavy

sedative actually makes patients in extreme pain more alert.

"Pain itself is an extremely potent depressant," Doctor Werner says. "It's almost as though the patient is curling around the pain. It's the central focus in their life. You take that away and all of a sudden they have the ability to start concentrating on their family and other concerns."

But the real key to the success of the program has been volunteer work, Doctor Werner says. Nurses, clergy and social workers are backed by laypeople who get a 25-hour training program (including instruction on basic nursing skills like moving a person from a bed to wheelchair, and discussion on topics like pain control, religious attitudes towards death, and legal issues like wills and insurance).

The goal is to keep the patient at home with their family as much as possible.

"The hospice to a certain extent is providing the extended family and support systems to enable a family to cope," Doctor Werner says.

During its first nine months of operation the hospice team worked with 20 patients. In all cases pain was brought under control, Doctor Werner said. And 75 percent of the patients stayed at home until death.

The focus on home care does not represent a bias against hospitals, hospice workers are quick to point out.

"We're not against hospitalization. But there are a fair number of people who would not choose to be in the hospital, and just don't realize they have other options," says Stephanie Chard, a hospice nurse.

Hospice work is a mixture of roller-coaster highs and lows.

"It's hard to know that inevitably you're going to lose somebody you've come to care about," Ms. Chard says.

"But perhaps we can create a situation where someone is allowed to live fairly productively for the amount of time they have left. That's the satisfying part."

Yardsticks of success

A medical program in which every patient dies must use yardsticks other than recovery rates to measure success. Bay De Noc has several indicators to choose from.

Community support for the pro-

gram has snowballed. In the first four months of this year \$8,500 was donated towards a \$10,000 budget. But a large share of that budget, \$4,000, is earmarked to pay volunteer expenses.

And that has been a problem.

"The bums' won't turn in their expense vouchers," Doctor Werner says. "Or when they hand in their voucher they'll write on the bottom, 'This is a donation. Don't pay me.'"

St. Francis Hospital in Escanaba has been an early and enthusiastic supporter of the hospice concept. When program patients are admitted, hospital staff follow hospice pain control treatments. "They're very receptive" to the hospice philosophy, Doctor Werner says.

But personal testimonials may be the most satisfying measure of success.

Caring for a dying person "is a terrifying thing," Peggy Bryson says. "When we did things and the hospice said we were doing them the right way, it gave us all confidence."

The Brysons' hospice nurse, Vi DeGrand, once chewed the family out for not calling her in the middle of the night when Lucille was in pain. Thereafter, the family never hesitated to call when they needed help.

"You expect late calls," Ms. DeGrand says, shrugging the incident off. Now a friend of the family, she stops by to chat with Ray and have a cup of coffee.

Lucille Bryson died last Christmas eve. Her final months were relatively pain-free. "We had many nice days and times," Peggy Bryson remembers.

Although Lucille went into the hospital just before her death, family — and the hospice volunteers — were with her when she died.

"It was very emotional," Peggy Bryson says. "But it was beautiful."

Perhaps a measure of the hospice program's success might be the distance between that scene and the picture of a couple sitting on the edge of a bed at 4 a.m. holding each other against pain that would not stop.

Michigan Gov. William G. Milliken has designated June 1-7 as Michigan Hospice Week, to begin informing the public and raising members and funds for the Michigan Hospice Organization.

Michigan hospices organizing

Community Hospice, Inc. Flint

Hospice of Flint (now Community Hospice, Inc.) has brought together a consortium of health care providers and outlined a common strategy for providing services to the terminally ill.

The board of directors has decided to work with existing service providers in developing a community-wide hospice program, or a "Hospice Without Walls," a program which coordinates, develops, and provides hospice services in the home and inpatient setting, but does not own or operate an inpatient facility.

Community Hospice will not become a provider of service unless existing providers are unable to satisfy an identified need. Instead, Community Hospice will serve as the coordinating body for service to the terminally ill and the advocate for the dying patient.

Community Hospice has developed a draft program outline and is in the process of making application to Blue Cross/Blue Shield of Michigan for status as a pilot project. Currently, BCBSM plans to fund four pilot hospice programs in Michigan. Community Hospice is optimistic that its application will be competitive and be approved as a pilot project.

Good Samaritan Hospice Care, Inc. Battle Creek

Good Samaritan Hospice Care, Inc. was organized in December by representatives of five Battle Creek area hospitals, two medical doctors and the community's Visiting Nurse Service director.

Hospice home care is our primary goal, with hospital in-patient status at the hospital of the patient's choice if home care ceases to be feasible.

The support and assistance of the two doctors, one specializing in oncology, the other a colon-rectal surgeon, provides proof to the medical community that hospice will eventually be a functioning, support-

ive program to assist them and their patient during the terminal phase of life.

Critical to the management of hospice care, is knowledgeable medical direction. Our hospice plan emphasizes the primary physician's direction of the patient's home care program, as well as the primary physician working cooperatively with the hospice interdisciplinary team to effectively identify and handle symptom management.

When symptom control needs to be supplemented, the primary physician may consult with the Hospice Medical Committee for hospice management.

We foresee that a medical committee may be a realistic alternative for our community hospice rather than one physician, as all of our committed physicians have busy, active practices.

Grand Traverse Area Hospice

The Grand Traverse Area Hospice is a community-based, medically-directed organization committed to providing comprehensive care to terminally ill patients and their families in various settings. Our hospice operates by the standards of care developed by the National Hospice Organization. Services are provided to both in-patients and out-patients, although primary focus is on assisting the patient and family in the home setting. To date, we have assisted 35 patients and families.

Judith Ramsdell, MD, oncologist, and Lee Hawkins, MD, internist, are members of the coordinating task force, and act as standards and policy advisors. They and other physicians from both Munson Medical Center and Traverse City Osteopathic Hospital provide palliative care and alleviation of symptoms attendant with terminal illness.

A patient referred to hospice must have an attending physician. He or she may initiate referral to hospice and/or must approve patient participation before hospice services may be provided. The physician continues to be kept abreast of all developments of patient progress.

Patients are referred when diagnosed as terminally ill with six months or less to live. A variety of diagnoses and all ages are served. An interdisciplinary team assesses appropriateness for program involvement.

Physician referral and supervision in addition to frequent team conferences have been responsible for the success attained thus far.

Hospice of Lansing

Hospice of Lansing, Inc., was formed by a group of consumers in December, 1978. Our aim is to facilitate an interdisciplinary program of hospice care for terminally-ill patients and their families in the Lansing area.

An early feasibility study of the Tri-County Area (Ingham, Eaton, Clinton) confirmed our supposition that there are few alternatives to a hospital death for patients in this area, with support services fragmented if and where they do exist.

The next project was the development of a recruitment and training program for volunteers. Hospice of Lansing plans a home care program exclusively; thus volunteers become a keystone of the program's success.

As of this writing, it is our intention to begin giving active care in July of this year. We intend to start on a small scale, servicing the needs of five patients and families for the first six months to one year. We have commitments from two local physicians to refer three and two patients to us, respectively.

These physicians have agreed to do home visits as needed for their own patients, with back-up being provided by our part-time medical director, Heidi Joos, MD. Doctor Joos is a family practitioner who worked as staff physician at Hospice of New Haven (Connecticut) for two years while studying at the Yale Divinity School.

Hospice of Saginaw

Hospice of Saginaw, Inc., is a non-profit corporation established to provide specialized home care services to dying patients and their families. We provide medical, social, emotional and spiritual support to the pa-

ent and family using a wide array of volunteers: physician, nurses, social workers, clergy, and lay persons.

Patients are referred to us by family physicians, hospital staffs and family members on a regular basis. We work closely with local hospitals and other home health care agencies in the planning and delivery of complementary services to mutual clients.

While the home care program is our organization's primary emphasis, we do have other goals that complement home care and address the needs of the larger community.

Hospice will soon offer bereavement counseling services to local hospital emergency rooms on an on-call basis.

Community education programs and public speakers have been available to groups for the last 12 months. Our educational programs stress the meaning of hospice and present the special needs of the dying.

Hospice of Southeastern Michigan, Southfield

Hospice of Southeastern Michigan has been established by 12 hospital corporations, representing 21 hospitals in the Detroit metropolitan area. The founding of a hospice by a consortium of hospitals is a unique action, unprecedented, in the United States.

Located in Southfield, northwest of Detroit, the hospice is to open in early July and to offer a comprehensive program of care for patients with advance illness and their families.

In addition to the 42-bed inpatient facility, it will provide an extensive home care program utilizing the services of community agencies and specially trained volunteers; a bereavement follow-up service extending up to two years; a partial care program through which patients can remain at home for the day or night, returning to the hospice for continuing care; and a special program for children with fatal illness, in cooperation with Children's Hospital of Michigan.

The physician-directed hospice is to formalize a reimbursement agreement with Blue Cross/Blue Shield of Michigan this spring. It is licensed by the Michigan Department of Public Health, which has declared

it a demonstration project and will use the hospice's operating experience as a basis on which to design standards for other hospices throughout Michigan.

The new program has the exclusive support of the Greater Detroit Area Hospital Council and the Comprehensive Health Planning Council of Southeastern Michigan. It has been proposed for a pilot project under an agreement between Chrysler, Ford, General Motors and the United Auto Workers.

Hospice of Washtenaw, Inc. Ann Arbor

Hospice of Washtenaw began two years ago as a community planning project sponsored by the Washtenaw United Way. The involvement of the United Way in the project is one example of the broad community, professional and institutional support that, perhaps, makes Hospice of Washtenaw unique. The objectives of the project are to act as the individual and family's advocate, promote care at home and in the community as long as it is desirable, and to encourage cooperation among all caregivers.

Volunteers will be a major element in the Washtenaw hospice. Professional and lay volunteers will be selected and trained to work directly with individuals and families in a supportive role. Volunteers will help assess and arrange necessary professional, skilled and supportive services. Volunteers also will assist in administrative and other operational tasks of the agency.

A major objective will be to work closely with and link together available professionals and organizations in support of the dying individual and the family, avoiding duplication.

Hospices of Michigan Pleasant Ridge

Hospices of Michigan was established as a free-standing community-based hospice program and incorporated as a non-profit corporation in July, 1976. The corporation's objectives are to establish hospices and help others do so.

After considerable study, the founding members of Hospices of Michigan decided that patients and

families would be served best by developing a coordinated home care hospice program.

At this writing the representatives of many of the home health care agencies in Southeast Michigan have agreed to participate in such a coordinated home hospice care program, but formal arrangements have not been concluded and volunteers still must be trained before we can accept patients.

Palliative Care Unit — Harper-Grace Hospitals

Several oncology physicians, nurses, social workers and chaplains recognized the need for hospice-type care for some in-patients at Harper Hospital. On April 3, the Palliative Care Unit at Harper Hospital was opened to a small number of carefully selected patients.

As the only patients eligible for transfer to the Palliative Care Unit are those who are nearing the end of life but still require the medical and nursing services of an acute hospital, the Unit cannot be looked upon as a hospice.

Yet, when a home care program has been initiated to serve the oncology patients at time of discharge from Harper-Grace Hospitals, the Palliative Care Unit can be expected to become an important part of a total hospice program.

Harper-Grace patients who have been followed at home by nurses from other agencies might be admitted directly to the Palliative Care Unit if at some time very late in the course of their illness their symptoms become uncontrollable at home.

Kalamazoo Hospice

In April, 1979, physicians, clergy, concerned citizens, and representatives of community medical support services began meeting to explore possibilities for hospice care in Kalamazoo. An initial needs assessment and inventory of available community services was done, and a need and desire for such care in our community became very clear.

At the end of the year, the Organizational Task Force submitted to the Kalamazoo Foundation a proposal endorsed by 19 key medical, religious, academic, and agency leaders. In January, 1980, the Foundation

MSMS supporting hospice

By Kevin A. Kelly, MSMS staff



The term "hospice" originally designated the way-stations or refuges where medieval pilgrims were sheltered, fed, and protected during their arduous journey to the Holy Lands.

Today, the hospice is a resource for the patient with a disease or con-

dition with a terminal or limited prognosis. Hospices originated in England, and various forms of hospice programs are emerging across the United States and the State of Michigan.

A hospice offers a program of care which provides palliative and supportive services in caring for the physical, psychological, social and spiritual needs of the terminally ill, with an emphasis placed on symptom control. Hospice care provides a full range of health services through an interdisciplinary team of professionals, with the medical services of a hospice being appropriately under the direction of a physician.

It is imperative that members of

the medical community understand the role of hospice care as it begins to develop its own niche in the health care delivery and reimbursement system of Michigan.

At its March 5 meeting the Michigan State Medical Society Council considered three resolutions with respect to hospice development in Michigan. The MSMS Council endorsed the concept of hospice programs as having an appropriate and humane role in the care of the terminally ill. The MSMS Council also approved a contribution of \$500 to be made to the Michigan Hospice Organization (MHO) — Public Education Project.

The MSMS Council referred consideration of any forthcoming hospice legislation to the MSMS Committee on State Legislation and Regulations for monitoring and assurance of medical quality control. Currently the MSMS Committee on State Legislation and Regulations is reviewing HB 4909, a bill introduced by Representative David Hollister that calls for the setting up of a licensing mechanism for hospice programs of care. (See related article, page 291.)

The Wayne County Medical Society has formed a task force on hospice care. The committee met the past several months to study the proposed hospice regulatory legislation and to make recommendations to ensure physicians could contribute to hospice development.

The Wayne Task force presented its recommendations May 16 to the WCMS Council. They called for the county medical society to encourage its members to participate in hospice programs, to identify physicians and other health care personnel who are interested in participating in development and promotion of hospice programs, to publish a series of articles in the *Detroit Medical News*, to participate in hospice home care programs, to recommend MSMS present a course on Hospice care at the 1980 Annual Scientific Meeting, and to offer, with MSMS, consultation in the development of state rules and regulations for hospices.

The WCMS Hospice Task Force was chaired by George Fisher, MD. Members were William Simpson, MD; Philip Maloney, MD; George Dean, MD; Walter Hassig, MD, and Ramesh Mohindra, MD

PROGRESS/continued

granted us operating expenses for a planning year. Subsequently we received a gift from one of the foundation trustees, and we expect a final grant soon to complete our proposed operating expense budget for the planning year. We also have received a grant to provide training opportunities at other hospices for Kalamazoo program developers and personnel, and to bring experts here for training and educational meetings.

Three physicians are among the 14 members of the Steering Committee: Leo Zerkowicz, MD, of Oncology and Hematology, PC, a founding member; Raymond S. Lord, MD, of Kalamazoo Cancer Center, PC; and Donald A. Schon, MD, of the Michigan Nephrology Center.

Lake Superior Hospice Association, Inc. Marquette

Our hospice is presently in the development and training phase. We are incorporated and are anticipating our tax-exempt status to be approved in the near future.

Our board of directors is made up of five registered nurses, two physicians, two Lutheran ministers, one Catholic priest, one teacher, and

one accountant. The board members are the source of the hospice's development, and training of our volunteers.

We believe most of our revenue will come through fund raising and donations. Membership dues in Lake Superior Hospice are a minimum of \$2 annually. We project a beginning annual budget of approximately \$10,000 which does not include salaries, since everyone is volunteer at this time.

The Lake Superior Hospice Association came into existence in January 1979 and was incorporated in October. We have developed slowly to help insure the highest quality program possible. During our first year we primarily educated our community about hospice care and this is a continuing project. We now believe we are ready to go forth and train our volunteers and begin giving service.

Hospices which did not submit summaries by deadline are Citizens for Hospice, Coldwater; Metropolitan Hospital Hospice, Detroit; Hospice of Greater Grand Rapids; FISH Hospice, Lake Orion, and Human Support Group, Northern Michigan Hospitals, Inc., Petoskey.

DESCRIPTION: Methyltestosterone is 17 β -Hydroxy-17-Methylandrosta-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunuchism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-puberal cryptorchidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric,

avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE**

REACTIONS: Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. **In the male:** Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpuberal cryptorchism, 30 mg. **REFERENCE:** R. B. Greenblatt, M.D.; R. Witherington, M.D.; I. B. Sipahioglu, M.D.: Hormones for Improved Sexuality in the Male and the Female Climacteric. *Drug Therapy*, Sept. 1976. **SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only

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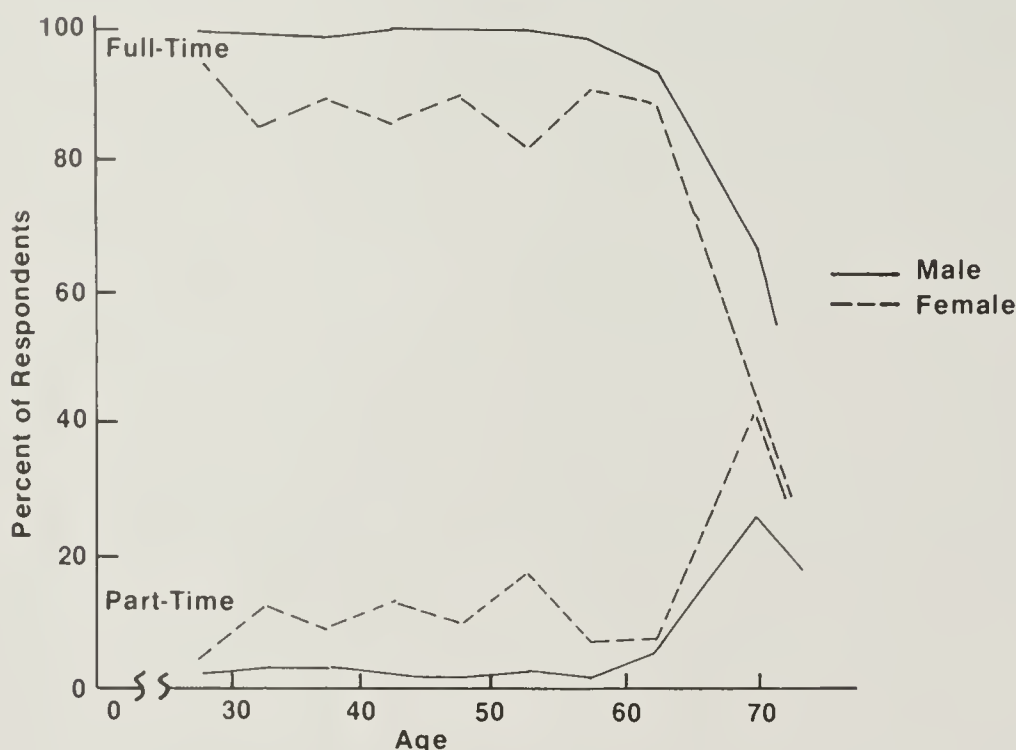
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New data show number, location, specialty of Michigan physicians

Figure 1
Percent distribution of active medical doctors in Michigan by employment status, according to age and sex 1978



The following are highlights of the data on numbers of MDs in Michigan. The data are by the Michigan Cooperative Health Information System and published in December 1979. The MCHIS publishes a continuing series of data reports on licensed health occupations in the state, with the cooperation of groups involved, including MSMS.

1973-1978

The number of medical doctors located in Michigan increased from 9,915 in 1973 to 11,768 in 1978, an increase of 19 percent, while the number of out-of-state licensees increased between 1973 and 1976 and then decreased in 1977 and 1978. This decrease may be partially explained by a continuing education requirement which went into effect in December, 1976, encouraging out-of-state and inactive licensees to drop their Michigan licenses. An increase of 1.6 percent in the estimated percent of all physicians active from 1976 to 1978 may further reflect the

effect of the change in education requirement. An increase occurred in every location. In 1978, about 98 percent of the MDs in each area of the state were active.

Data from the 1976 survey have been published in a previous MCHIS report. For many of the demographic variables in the 1976 survey, the non-response rates were relatively high. The 1978 survey data have generally lower non-response rates and, thus, more refined data.

1978

Geographic Location

In 1978, 15,540 medical doctors were licensed by Michigan. Of the 11,768 licensees located in Michigan, 7,417 (63 percent) were located in Southeast Michigan (Area 1). Eight Michigan counties (Wayne, Oakland, Washtenaw, Kent, Genesee, Macomb, Ingham and Kalamazoo) each had 400 or more medical doctors and together included 78 percent of all medical doctors in Michigan, with 22 percent in the remaining 75 counties. Two counties (Montmorency and Keweenaw) had no medical doctors.

Sex and Race

Of the 11,768 licensees in Michigan, 10,619 (90.2 percent) were male and 1,118 (9.5 percent) were female.

Of the males, 72.5 percent were white and 10.3 percent were Oriental, compared to 48.2 percent and 23.5 percent, respectively, of the females. Only about two percent of each group was black. These percentages are subject to considerable error because of the high proportions (14.3 percent of the males and 25.3 percent of the females) for whom race was not reported.

Employment Status

Ninety-four percent of the licensees in Michigan were active full-time. An additional 4.5 percent were active part-time and 1.5 percent were inactive.

The proportions active (full-time or part-time) were comparable for males and females, though the females had lower percentages working full-time and higher proportions working part-time than did the males.

In every age group younger than 65 years, 90 percent or more of the males and 80 percent or more of the females were active full-time (Figure 1). In each of the three specified racial groups (white, black and oriental), over 90 percent of the licensees were active full-time in each age group under 60.

Age

About 37 percent of the active licensees in Michigan were under 40 years of age, but this proportion varied by sex and race. About 54 percent of the females were under 40 compared to about 36 percent of the males, and about 62 percent of the Orientals were under 40 compared to about 28 percent for both Whites and Blacks. Both the female and Oriental groups have low proportions in the ages over 60 in comparison to males or to the White and Black groups.

(continued on page 300)

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Figure 2
Percent distribution of active medical doctors in Michigan
by place of medical education and by school for those educated
in Michigan
1978

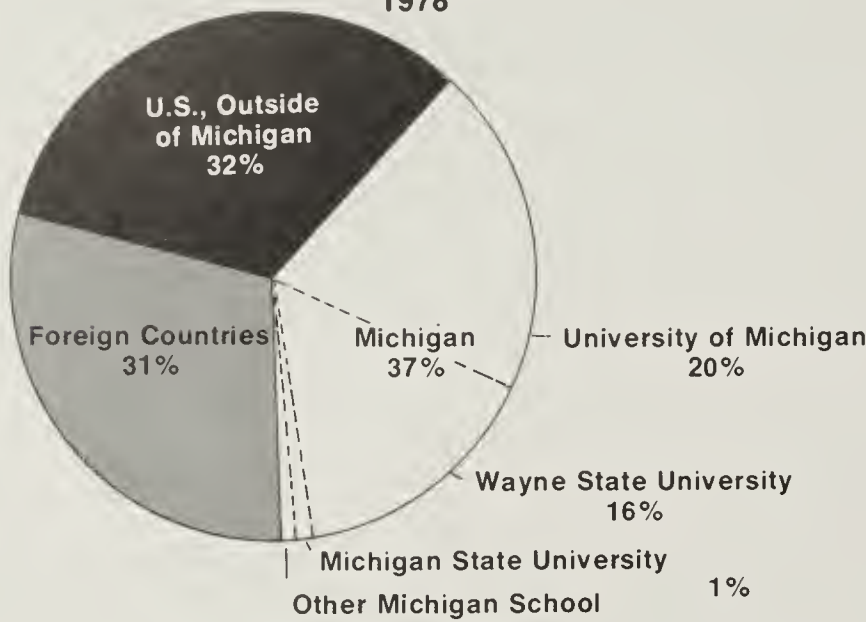


Table A

Percent distribution of active medical doctors by principal specialty, United States (1976)¹ and Michigan (1978)

(Percent distribution is based on data self-reported by the M.D.'s. Sums may not total 100.00 due to rounding.)

Principal Specialty	Percent of Active M.D.'s	
	U.S. (1976)	Michigan (1978)
All Specialties	100.00	100.00
Primary Care ² Specialties	45.35	45.88
Medical Specialties	5.44	5.14
Surgical Specialties	21.96	22.01
Other Specialties ³	27.25	26.98

¹ "Health, United States, 1978," DHEW Publication No. (PHS) 78-1232, December, 1978, Table 125, p. 340.

² Includes obstetrics and gynecology.

³ Includes "specialty not reported."

Education

The proportion of active medical doctors in Michigan who received their professional education in the United States varied by year of graduation. Of those graduating before 1940, about 91 percent were educated in the U.S.; the proportion fell to 51.4 percent of those graduating during the 1960's, but had increased to 72.5 percent of those graduating in the 1970's.

The areas outside the United States with the highest representation among the graduates of the 1960's were Central and Eastern Asia

and the Philippines, and it is these areas that show the greatest drops in representation among those medical doctors graduating since 1970.

About 37 percent of the active medical doctors in Michigan received their professional education in Michigan (Figure 2). Of the Michigan graduates, about 54 percent were from the University of Michigan, 43 percent from Wayne State University, and 2 percent from Michigan State University. The proportions vary by year of graduation, with a decline in recent years in the proportions educated at the University of Michigan

and an increase in the proportions educated at Wayne State University and Michigan State University.

More than 1,500 of the licensees reported that they were in residency or fellowship programs at the time of the survey. Nearly 1,300 of these were located in Southeast Michigan (Area 1), but there were some in each area of the state. All but two of the 1,575 residents or fellows reported that they were active in medicine. Nearly 800 were in a primary-care specialty.

Specialty

Of all the active medical doctors in Michigan, including residents and fellows, about 46 percent reported, as their principal specialty, a primary-care specialty (family or general practice, internal medicine, obstetrics and gynecology, or pediatrics); five percent reported a medical specialty; 22 percent reported a surgical specialty; 24 percent reported another specialty; and three percent did not report their principal specialty (Table A). These percents are similar to the percents for the United States in 1976.

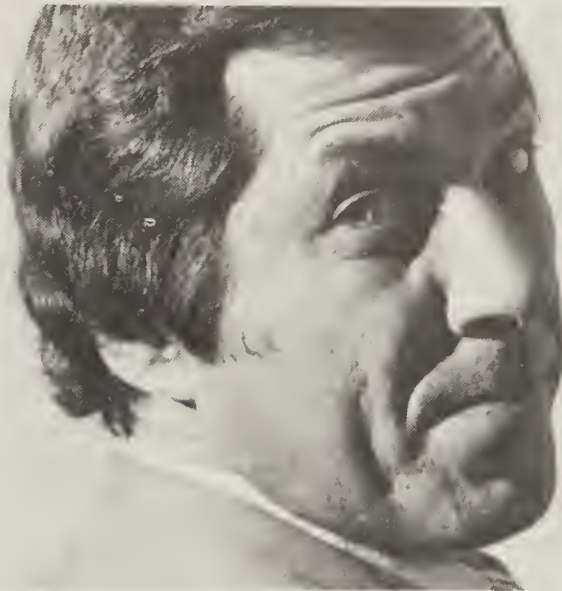
About 50 percent of the active medical doctors in Michigan were certified in their principal specialty and an additional 25 percent were eligible for certification. The percent certified varied by specialty group, ranging from 45.4 percent of those in primary-care specialties to 63.0 percent of those in surgical specialties (Figure 3). Four specialties (ophthalmology, otorhinolaryngology, pathology and radiology) had especially high proportions of medical doctors with board certification, with more than 100 reporting each specialty. A secondary specialty was reported by 26 percent of the active respondents in Michigan. The MD group whose principal specialty was a medical specialty had the highest proportion (58 percent) who reported a secondary specialty.

The estimated 5,317 active medical doctors in Michigan whose principal specialty was a primary-care specialty included 719 in family practice, 932 in general practice, 1,958 in internal medicine, 864 in obstetrics and gynecology, and 844 in pediatrics.

An estimated 49 percent (5,687 out of 11,590) of the medical doctors

(continued on page 302)

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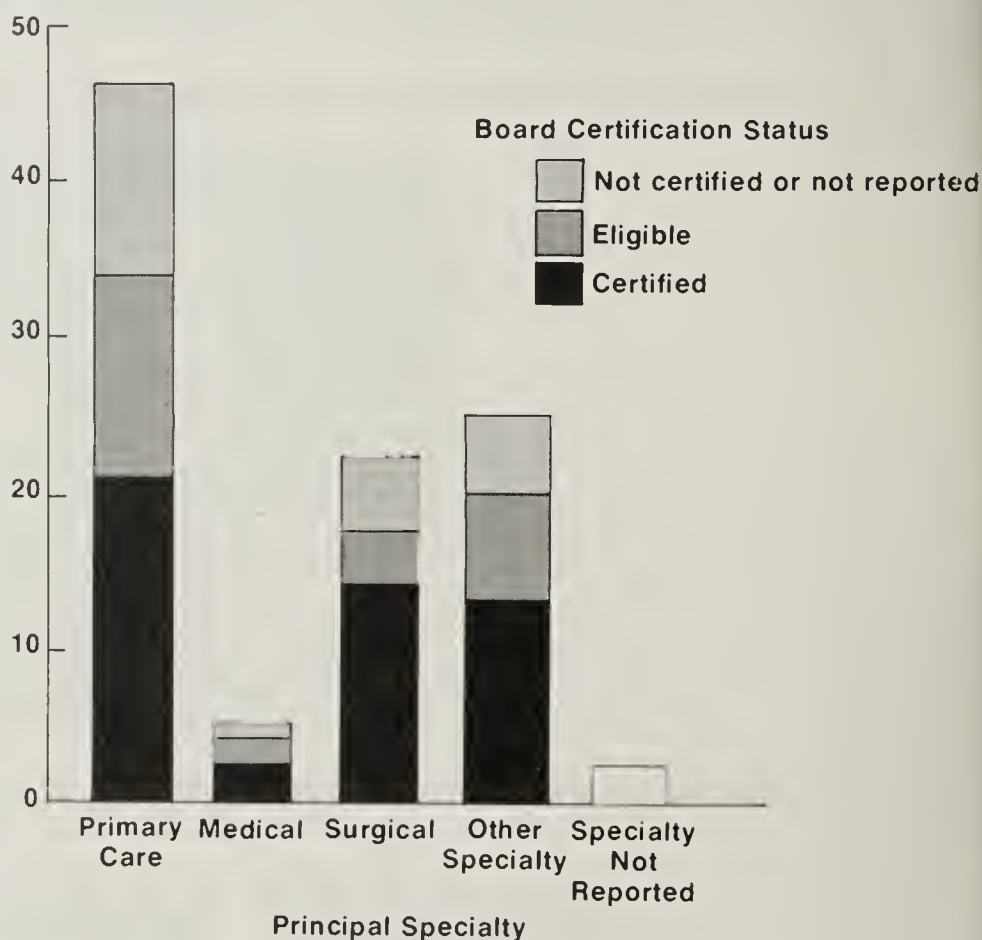
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STATISTICS/continued

worked principally in a practitioner's office, and an additional 37 percent (4,321 out of 11,590) worked principally in hospitals. About 60 percent of the MDs were self-employed, but the percentages varied widely according to work setting.

About 89 percent of the medical doctors worked principally in patient care, the most frequently reported type of work for each work setting. The average number of hours worked per week by the active medical doctors was 54.5. About 97 percent of the active medical doctors spent some time in patient care, working an average of 47.6 hours per week in this type of work. The remaining types of work (teaching, administration, research, retail/wholesale trade, other activities) each involved a much lower proportion of the active physicians (less than 40 percent), and a much smaller average number of hours per week (less than 10).

Figure 3
Percent distribution of active medical doctors in Michigan by principal specialty and board certification status



AMA volume has national MD statistics

There is one physician for every 535 persons in the United States.

Of the nation's 375,811 active physicians, 91.2 percent are engaged in direct patient care, bringing the ratio of physicians, excluding those who are employed by the US government, to 187 physicians per 100,000 persons.

Washington, DC ranks first among cities in the number of physicians, with 524 per 100,000 population. South Dakota ranks last among the states with 106 physicians per 100,000 people.

These facts are contained in the recently released American Medical Association's 16th edition of *Physician Distribution and Medical Licensure in the U.S., 1978*.

The 388-page volume, prepared by the AMA's Center for Health Services Research and Development, is comprised of statistical information from the AMA Physician Masterfile,

the most comprehensive and complete source of physician data in the US.

Information covering the ratio of physicians, excluding those in government (federal), in the US reveals that New England has the highest ratio (238) and the lowest (134) is in the South Central division (Alabama, Kentucky, Tennessee and Mississippi).

In the area of physician manpower, the section describes the distribution of 375,811 physicians who are professionally active in the US and possessions. The majority of active physicians, 342,714 or 91.2 percent, are classified in "patient care." Of the physicians engaged in "patient care," 54,893 are in general practice which includes family practice; 96,940 are in medical specialties; 98,567 are involved in surgical specialties and another 92,314 in "other specialties."

Of the 45,540 women physicians, approximately 6,688 more than in 1976, 11,979 are engaged in medical specialties and another 12,251 are involved in "other specialties."

Statistical information on physician location, specialty and professional activity, compiled by the AMA Center for Health Services Research and Development, comprise *Physician Distribution*. Cost is \$15 each for 1-10 copies; \$14.50 each for 11-49; \$14 each for 50 copies or more; and \$21 on foreign orders. To order, write OP-071, AMA Order Department, P.O. Box 821, Monroe, Wis., 53566.



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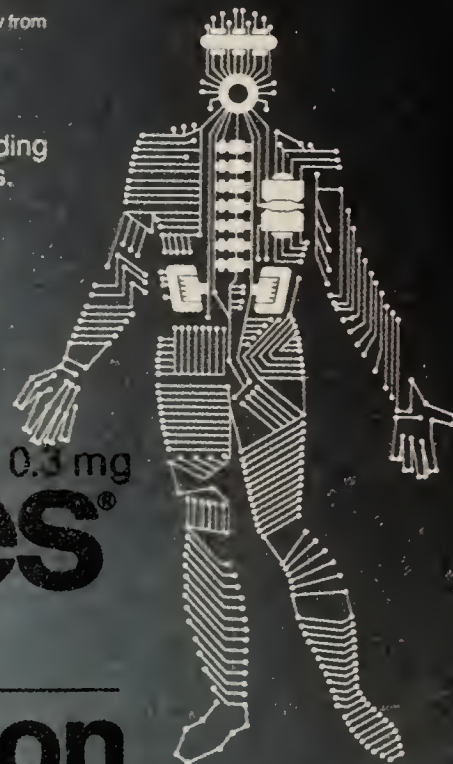
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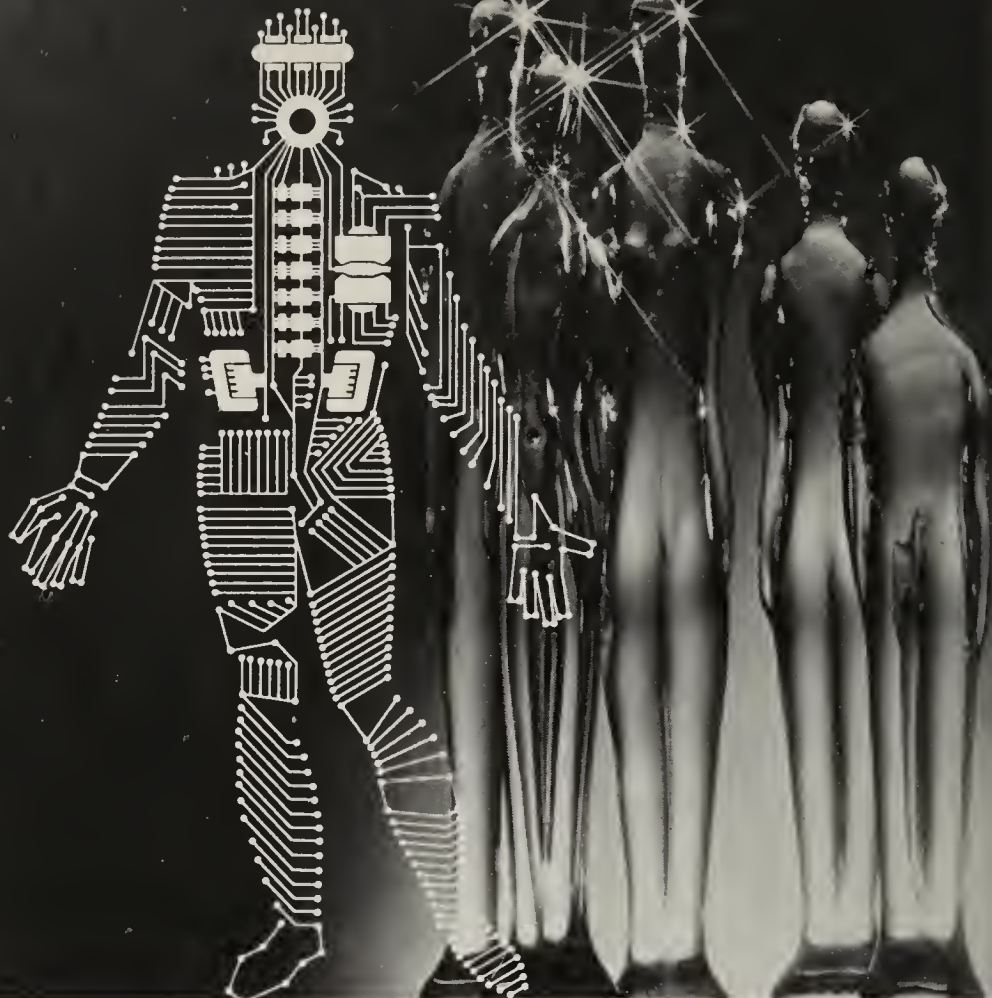
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Usage in Pregnancy: In view of embryotoxic findings in animals, and since information on possible adverse effects in pregnant women is limited to uncontrolled clinical data, the drug is not recommended in women who are or may become pregnant unless the potential benefits outweigh the potential risk to mother and fetus.

Usage in Children: No clinical experience is available with the use of Catapres (clonidine hydrochloride) in children.

Precautions: When discontinuing Catapres (clonidine hydrochloride), reduce the dose gradually over 2 to 4 days to avoid a possible rapid rise in blood pressure and associated subjective symptoms such as nervousness, agitation, and headache. Patients should be instructed not to discontinue therapy without consulting their physician. Rare instances of hypertensive encephalopathy and death have been recorded after cessation of clonidine hydrochloride therapy. A causal relationship has not been established in these cases. It has been demonstrated that an excessive rise in blood pressure, should it occur, can be reversed by resumption of clonidine hydrochloride therapy or by intravenous phentolamine. Patients who engage in potentially hazardous activities, such as operating machinery or driving, should be advised of the sedative effect. This drug may enhance the CNS-depressive effects of alcohol, barbiturates and other sedatives. Like any other agent lowering blood pressure, clonidine hydrochloride should be used with caution in patients with severe coronary insufficiency, recent myocardial infarction, cerebrovascular disease or chronic renal failure.

As an integral part of their overall long-term care, patients treated with Catapres (clonidine hydrochloride) should receive periodic eye examinations. While, except for some dryness of the eyes, no drug-related abnormal ophthalmologic findings have been recorded with Catapres (clonidine hydrochloride), in several studies the drug produced a dose-dependent increase in the incidence and severity of

The usual starting dose of Catapres is 0.1 mg at breakfast and 0.1 mg at bedtime. Some patients may benefit from a starting dose of 0.1 mg at bedtime.

Usual daily dose range—0.2 — 0.8 mg

Maximum daily dose—2.4 mg

Doses as high as this have rarely been employed.

For optimal results, the dose of Catapres must be adjusted according to the patient's individual blood pressure response.

spontaneously occurring retinal degeneration in albino rats treated for 6 months or longer.

Adverse Reactions: The most common reactions are dry mouth, drowsiness and sedation. Constipation, dizziness, headache, and fatigue have been reported. Generally these effects tend to diminish with continued therapy. The following reactions have been associated with the drug, some of them rarely. (In some instances an exact causal relationship has not been established.) These include: Anorexia, malaise, nausea, vomiting, parotid pain, mild transient abnormalities in liver function tests; one report of possible drug-induced hepatitis without icterus and hyperbilirubinemia in a patient receiving clonidine hydrochloride, chlor-thalidone and papaverine hydrochloride. Weight gain, transient elevation of blood glucose, or serum creatine phosphokinase; congestive heart failure, Raynaud's phenomenon; vivid dreams or nightmares, insomnia, other behavioral changes, nervousness, restlessness, anxiety and mental depression. Also rash, angioneurotic edema, hives, urticaria, thinning of the hair, pruritus not associated with a rash, impotence, urinary retention, increased sensitivity to alcohol, dryness, itching or burning of the eyes, dryness of the nasal mucosa, pallor, gynecomastia, weakly positive Coombs' test, asymptomatic electrocardiographic abnormalities manifested as Wenckebach period or ventricular trigeminy.

Overdosage: Profound hypotension, weakness, somnolence, diminished or absent reflexes and vomiting followed the accidental ingestion of Catapres (clonidine hydrochloride) by several children from 19 months to 5 years of age. Gastric lavage and administration of an analeptic and vasopressor led to complete recovery within 24 hours. Tolazoline in intravenous doses of 10 mg at 30-minute intervals usually abolishes all effects of Catapres, (clonidine hydrochloride) overdosage.

How Supplied: Catapres, brand of clonidine hydrochloride, is available as 0.1 mg (tan) and 0.2 mg (orange) oval, single-scored tablets in bottles of 100 and 1000. Also available as 0.3 mg (peach) oval, single-scored tablets in bottles of 100.

For complete details, please see full prescribing information.

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MSMS, MSMS/A, AMA, and medical assistants

June 15-17 — AMA National Conference on Negotiating Physicians' Compensation, Loew's L'Enfant Plaza, Washington, DC, contact: AMA Department of Negotiations, 535 N. Dearborn St., Chicago, 60610.

July 10-13 — MSMS Council, Holiday Inn, Marquette, contact: Warren Tryloff, MSMS headquarters.

July 20-24 — AMA Annual Meeting, Chicago Marriott Hotel, contact: AMA, 535 N. Dearborn St., Chicago, 60610.

July 26-27 — Summer Seminar, State of Michigan Branch, American Association of Medical Assistants, Marquette, contact: Caroline Rich, MSMS headquarters.

Sept. 10 — MSMS Council, MSMS headquarters, contact: Warren Tryloff, MSMS headquarters.

Sept. 10-18 — MSMS/Intrav Swiss Adventure, contact: Marcelyn Ireland, MSMS headquarters.

Sept. 10-29 — MSMS/Intrav China Adventure, contact: Marcelyn Ireland, MSMS headquarters.

Oct. 22 — MSMS Council, MSMS headquarters, contact: Warren Tryloff, MSMS headquarters.

Oct. 24-25 — AMA Fourth National Conference on Medical Care and Health Services in Correctional Institutions, Chicago, contact: AMA Correctional Programs, 535 N. Dearborn St., Chicago, 60610.

Nov. 18-20 — MSMS Annual Scientific Meeting, Hyatt Regency Dearborn, contact: Sherry Fent, MSMS headquarters.

Dec. 3 — MSMS Council, MSMS headquarters, contact: Warren Tryloff, MSMS headquarters.

Other meetings

June 26-27 — Annual Meeting, Michigan Hospital Association, Grand Hotel, Mackinac Island, contact: Michigan Hospital Association, 2213 E. Grand River Ave., Lansing, 48912.



July 8-10 — Annual Scientific Meeting, Michigan Chapter, American Academy of Pediatrics, Bay Valley Inn, Bay City, contact: Miles Tiernan, 32245 Hearthstone, Farmington Hills, 48018, 313/553-3646.

July 16 — Board meeting, Michigan Chapter, American College of Emergency Physicians, MSMS headquarters, contact: Michigan Chapter ACEP, P.O. Box 1611, East Lansing, 48823, 517/332-6500.

Aug. 22-24 — 21st Congress of the Professions, Boyne Highlands, contact: Michigan Association of The Professions, 1407 S. Harrison Rd., P.O. Box 946, East Lansing, 48823, 517/337-1725.

Sept. 3 — Board meeting, Michigan Chapter, American College of Emergency Physicians, MSMS headquarters, contact: Michigan Chapter, ACEP, P.O. Box 1611, East Lansing, 48823, 517/332-6500.

Sept. 25-27 — 1980 Walter P. Work Society, Stanford Court Hotel, San Francisco, contact: Nels R. Olson, MD, Box 61, University Hospital, Ann Arbor, 48109.

Nov. 5 — Board meeting, Michigan Chapter, American College of Emergency Physicians, MSMS headquarters, contact: Michigan Chapter, ACEP, P.O. Box 1611, East Lansing, 48823, 517/332-6500.

Health Occupations Council receives Kellogg Grant

The Michigan Health Occupations Council (HOC) Lansing has a grant of \$198,536 from the Kellogg Foundation to help carry out its mission under the state Public Health Code. The University of Michigan (U-M) is cooperating in the project and will serve as the grant's fiscal agent.

The 29-member HOC was created under the Code in 1978 as an advisory body to the governor, the legislature and the Department of Licensing and Regulation on a variety of health professional and occupational regulation issues.

L and R Director William Balenger said the grant was requested because the Health Code makes extraordinary demands on the HOC to complete a number of projects during its first two years of existence.

Under terms of the grant, U-M will provide personnel to work in four primary areas of the HOC's mandate.

MSMS officers

MSMS leaders

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James D. Fryfogle, MD, Southfield, President-elect
Robert M. Leitch, MD, Battle Creek, Secretary
Leland E. Holly II, MD, Muskegon, Treasurer
David Siegel, MD, Lansing, Speaker, MSMS House of Delegates
Gerald H. Mandell, MD, Detroit, Vice Speaker
Ernest P. Griffin Jr., MD, Flint, Immediate Past President
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azatadine maleate, 1 mg. tablets

CONTRAINDICATIONS Use in Newborn or Premature Infants. This drug should not be used in newborn or premature infants.

Use in Nursing Mothers. Because of the higher risk of antihistamines for infants generally and for newborns and premature infants in particular, antihistamine therapy is contraindicated in nursing mothers.

Use in Lower Respiratory Disease: Antihistamines should NOT be used to treat lower respiratory tract symptoms including asthma.

Antihistamines are also contraindicated in the following conditions: hypersensitivity to azatadine maleate and other antihistamines of similar chemical structure, monoamine oxidase inhibitor therapy (See DRUG INTERACTIONS Section).

WARNINGS Antihistamines should be used with considerable caution in patients with: narrow angle glaucoma; stenosing peptic ulcer, pyloroduodenal obstruction; symptomatic prostatic hypertrophy; bladder neck obstruction.

Use in Children: In infants and children especially, antihistamines in overdosage may cause hallucinations, convulsions, or death.

As in adults, antihistamines may diminish mental alertness in children. In the young child, particularly, they may produce excitation.

OPTIMINE TABLETS ARE NOT INTENDED FOR USE IN CHILDREN UNDER 12 YEARS OF AGE.

Use in Pregnancy Experience with this drug in pregnant women is inadequate to determine whether there exists a potential for harm to the developing fetus.

Use with CNS Depressants. Azatadine maleate has additive effects with alcohol and other CNS depressants (hypnotics, sedatives, tranquilizers, etc.).

Use in Activities Requiring Mental Alertness. Patients should be warned about engaging in activities requiring mental alertness, such as driving a car or operating appliances, machinery, etc.

Use in the Elderly (approximately 60 years or older): Antihistamines are more likely to cause dizziness, sedation, and hypotension in elderly patients.

PRECAUTIONS Azatadine maleate has an atropine-like action and, therefore, should be used with caution in patients with: a history of bronchial asthma, increased intraocular pressure, hyperthyroidism, cardiovascular disease, hypertension.

DRUG INTERACTIONS MAO inhibitors prolong and intensify the anticholinergic (drying) effects of antihistamines. **ADVERSE REACTIONS** The most frequent adverse reactions are underlined.

General: Urticaria, drug rash, anaphylactic shock, photosensitivity, excessive perspiration, chills, dryness of mouth, nose, and throat.

Cardiovascular System: Hypotension, headache, palpitations, tachycardia, extrasystoles.

Hematologic System: Hemolytic anemia, thrombocytopenia, agranulocytosis.

Nervous System: Sedation, sleepiness, dizziness, disturbed coordination, fatigue, confusion, restlessness, excitation, nervousness, tremor, irritability, insomnia, euphoria, paresthesias, blurred vision, diplopia, vertigo, tinnitus, acute labyrinthitis, hysteria, neuritis, convulsions.

Gastrointestinal System: Epigastric distress, anorexia, nausea, vomiting, diarrhea, constipation.

Genitourinary System: Urinary frequency, difficult urination, urinary retention, early menses.

Respiratory System: Thickening of bronchial secretions, tightness of chest and wheezing, nasal stuffiness.

OVERDOSAGE Antihistamine overdosage reactions may vary from central nervous system depression to stimulation. Stimulation is particularly likely in children. Atropine-like signs and symptoms (dry mouth; fixed, dilated pupils; flushing, and gastrointestinal symptoms) may also occur.

If vomiting has not occurred spontaneously, the patient should be induced to vomit. This is best done by having him drink a glass of water or milk after which he should be made to gag. Precautions against aspiration must be taken, especially in infants and children.

If vomiting is unsuccessful, gastric lavage is indicated within three hours after ingestion and even later if large amounts of milk or cream were given beforehand. Isotonic and 1/2 isotonic saline is the lavage solution of choice.

Saline cathartics, such as milk of magnesia, draw water into the bowel by osmosis and therefore are valuable for their action in rapid dilution of bowel content.

Stimulants should not be used.

Vasopressors may be used to treat hypotension.

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Questions on a wide variety of topics are asked daily of MSMS staff and leaders. They in turn draw on many expert resources to help MSMS members get good information. To better inform the membership, sample questions, with answers, are printed here. Future issues will carry more.



**FOR: Martha Powelson, Supervisor
Special Registration Unit, Michigan Secretary of State's Office**

"Is there a special parking permit available for a person who is temporarily handicapped?"

Yes. Our Special Registration Unit will issue a license plate identical to the regular plate for the handicapped, except that it expires in six months, instead of the usual four years. To arrange for such a license plate, a person must fill out an application, available at any Secretary of State office, and send it, along with a physicians' statement verifying the temporary handicap, to the Secretary of State Office, Treasury Building, Box 30045, Lansing, 48918. The license entitles the bearer to use any handicapped parking spaces for six months. There is no fee.

**FOR: John Anthony, general manager
MSMS/Physician Service Group, Inc.**



Mr. Anthony

"I think my office could be organized to run more smoothly. Does the medical society have any services to help its members better organize the business side of their practices?"

Yes, practice management is one of the major activities of the MSMS/Physician Service Group, Inc., in operation now one year. The PSG, in fact, now conducts in-office practice management consultations for established MDs, as well as management seminars for new physicians. During the past year, we have consulted with many physicians in a variety of different fields. An MSMS/PSG practice management consultation covers a variety of office operations such as accounting, office set-up, filing systems, scheduling, work flow, patient flow and personnel. Advice in these areas and others is available by contacting the MSMS/PSG at 517/337-1351.

**FOR: John Richards, chief
MSMS Bureau of Economics**



Mr. Richards

"How many HMOs in Michigan are receiving federal funding?"

Presently there are four pre-paid plans receiving federal funding:

Genesee Health Care, Inc. received federal support through feasibility, planning and development periods. Currently it is drawing on a \$2.28 million loan.

Family Health Care Plan of Kalamazoo has been awarded a federal feasibility grant of approximately \$60,000 to determine what is required to become federally qualified.

Group Health Plan of Southeastern Michigan receives federal support through feasibility, planning and development. It is currently drawing on a \$2.5 million loan.

Group Health Service of Michigan (Saginaw) is drawing on a \$2.5 million federal loan through 1984.

Health Central was supported during feasibility, planning and development; and used \$2.2 million of a \$2.5 million loan. The plan is not receiving federal funds at this time.



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MSMS House of Delegates photo highlights

Photos by Mert Scholten,
MSMS staff



1980-81 MSMS President John R. Ylvisaker, MD, left, escorts newly-chosen President-elect James D. Fryfogle, MD, to front of 1980 MSMS House of Delegates' annual session April 26 in Southfield.



Doctor Ylvisaker takes oath of office from MSMS Secretary Robert M. Leitch, MD, left, while Doctor Fryfogle, second from right and 1979-80 MSMS President Ernest P. Griffin, Jr., MD, witness.



A favorite part of the House of Delegates ceremonies each year is presentation of pins to physicians who graduated 50 years ago from medical school. Doctor Griffin, right, paid special recognition to MSMS Past President Orlen J. Johnson, MD.



Michigan's Lt. Gov. James Brickley, center, was a speaker at the annual MDPAC luncheon during the House of Delegates session, and met with MDPAC chairman Thomas C. Payne, MD, left, and AMPAC board member Thomas R. Berglund, MD.



A presidential Citation was awarded to Board of Medicine Immediate Past President John R. Wilson, MD, right, by Doctor Griffin.



MSMS leaders honor MSMS Director Warren F. Tryloff on his 25 years of service. From left they are Doctor Ylvisaker, Doctor Leitch, Mr. Tryloff, Doctor Griffin and MSMS Council Chairman Louis R. Zako, MD. (More on following page.)



Former AMA President Edward R. Annis, MD, right, confers with MSMS Past President Vernon V. Bass, MD, during a special forum on health care costs.

MSMS Director Warren F. Tryloff honored for 25 years of service



From left, Mrs. John R. Ylvisaker and Doctor Ylvisaker; Mrs. Warren F. Tryloff and Mr. Tryloff, at House of Delegates ceremonies.

One of the highlights for MSMS members and staff at the 1980 MSMS House of Delegates' Annual Session was a surprise presentation to Warren F. Tryloff. Mr. Tryloff, MSMS director since 1970, was honored for his 25 years of leadership to MSMS.

John R. Ylvisaker, MD, immediately following his inauguration as MSMS president, gave a suspenseful testimonial ending in a call for Mr. Tryloff to come forward during the installation banquet to receive his accolades.

"In 25 years of service to our Society," said Doctor Ylvisaker, "this man, despite his insistence on maintaining a low profile, has guided the destiny of the Society, managed its internal affairs for 15 of those years,

maintained continuity of purpose of the Society, orchestrated a continuous symphony of intricate and infinite variety, and kept his sanity and ours intact throughout."

Doctor Ylvisaker called Mr. Tryloff "quiet advisor, listener, stalwart supporter, objective analyst and every imaginable kind of helper . . ."

President Ylvisaker made the presentation with other officers on the platform: Past President Griffin, then-Speaker Fryfogle, Chairman Zako, Treasurer Holly, Secretary Leitch and Assistant Secretary Johnson.

Mr. Tryloff and his wife Nancy, who are members of the Baker Street Irregulars, were given an inscribed two volume annotated set of Sherlock

Holmes. In addition, they were given a weekend in New York City, at which time Mr. Tryloff will utilize a Dunhill Tailors gift certificate.

Joining MSMS in 1954 to head its Detroit office, Mr. Tryloff later became the associate public relations counsel and then assistant to the executive director. In this position he assisted Mr. William J. Burns in the overall management of the association, its annual scientific program and exhibit, and the annual House of Delegates meetings.

In a private gathering following the Saturday night affair, Doctor Ylvisaker said, "Warren is a very modest person who did some very interesting things in his career with little or no publicity." Because of his training as a convention manager, Mr. Tryloff was made president of the Professional Convention Management Association in 1970, a position which led to his serving as a consultant to international congresses such as the Royal Society of Medicine's "Advances in Medicine" meeting in London in July 1978.

Prior to this he was a member of the International Advisory Committee to Pan American Airways and Intercontinental Hotels. And he spoke to annual meetings of the European Federation of Conference Towns in Barcelona, Florence, Montreux, and London. In 1975, he and Mrs. Tryloff were guests of the French Tourist Commission, attending the opening ceremonies of the new Paris convention center.

Mr. Tryloff has surrounded himself with a remarkably able and loyal staff which permits him to serve as secretary of the Michigan Foundation for Medical and Health Education, continue his activity in the American Society of Association Executives, The American Association of Medical Society Executives and serve on the advisory committee to the editor of *Medical Meetings* magazine.

WHEN ANXIETY AND TENSION MAGNIFY PAIN

IN MUSCULOSKELETAL DISEASE*



A non-narcotic one-two punch against pain, with concurrent relief of anxiety/tension

EQUAGESIC[®] ^{IV}

(meprobamate and ethoheptazine citrate with aspirin) Wyeth

EQUAGESIC—Abbreviated Summary

***INDICATIONS:** Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:

"Possibly" effective for the treatment of pain accompanied by tension and/or anxiety in patients with musculoskeletal disease or tension headache. Final classification of the less-than-effective indications requires further investigation.

The effectiveness of Equagesic in long-term use, i.e. more than four months, has not been assessed by systematic clinical studies. The physician should periodically reassess usefulness of the drug for the individual patient.

CONTRAINDICATIONS: Equagesic should not be given to individuals with a history of sensitivity or severe intolerance to aspirin, meprobamate, or ethoheptazine citrate.

WARNINGS: Careful supervision of dose and amounts prescribed for patients is advised, especially with those patients with known propensity for taking excessive quantities of drugs. Excessive and prolonged use in susceptible persons, e.g., alcoholics, former addicts, and other severe psychoneurotics, has been reported to result in dependence on or habituation to the drug. Where excessive dosage has continued for weeks or months, dosage should be reduced gradually rather than abruptly stopped, since withdrawal of a "crutch" may precipitate withdrawal reaction of greater proportions than that for which the drug was originally prescribed. Abrupt discontinuance of doses in excess of the recommended dose has resulted in some cases in the occurrence of epileptiform seizures.

Special care should be taken to warn patients taking meprobamate that tolerance to alcohol may be lowered with resultant slowing of reaction time and impairment of judgement and coordination.

USAGE IN PREGNANCY AND LACTATION: An increased risk of congenital malformations associated with the use of minor tranquilizers (meprobamate, chlordi-

azepoxide, and diazepam) during the first trimester of pregnancy has been suggested in several studies. Because use of these drugs is rarely a matter of urgency, their use during this period should almost always be avoided. The possibility that a woman of child-bearing potential may be pregnant at the time of institution of therapy should be considered. Patients should be advised that if they become pregnant during therapy or intend to become pregnant they should communicate with their physicians about the desirability of discontinuing the drug.

Meprobamate passes the placental barrier. It is present both in umbilical-cord blood at or near maternal plasma levels and in breast milk of lactating mothers at concentrations two to four times that of maternal plasma. When use of meprobamate is contemplated in breast-feeding patients, the drug's higher concentrations in breast milk as compared to maternal plasma levels should be considered.

Preparations containing aspirin should be kept out of the reach of children. Equagesic is not recommended for patients 12 years of age and under.

PRECAUTIONS: Should drowsiness, ataxia, or visual disturbance occur, the dose should be reduced. If symptoms continue, patients should not operate a motor vehicle or any dangerous machinery. Suicidal attempts with meprobamate have resulted in coma, shock, vasomotor and respiratory collapse, and anuria. Very few suicidal attempts were fatal, although some patients ingested very large amounts of the drug (20 to 40 gm). These doses are much greater than recommended. The drug should be given cautiously, and in small amounts, to patients who have suicidal tendencies. In cases where excessive doses have been taken, sleep ensues rapidly and blood pressure, pulse, and respiratory rates are reduced to basal levels. Hyperventilation has been reported occasionally. Any drug remaining in the stomach should be removed and symptomatic treatment given. Should respiration become very shallow and slow, CNS stimulants, e.g., caffeine, Metrazol, or am-

phetamine, may be cautiously administered. If severe hypotension develops, pressor amines should be used parenterally to restore blood pressure to normal levels.

ADVERSE REACTIONS: A small percentage of patients may experience nausea with or without vomiting and epigastric distress. Dizziness occurs rarely when meprobamate and ethoheptazine citrate with aspirin is administered in recommended dosage. The meprobamate may cause drowsiness but, as a rule, this disappears as therapy is continued. Should drowsiness persist and be associated with ataxia, this symptom can usually be controlled by decreasing the dose, but occasionally it may be desirable to administer central stimulants such as amphetamine or mephentermine sulfate concomitantly to control drowsiness.

A clearly related side effect to the administration of meprobamate is the rare occurrence of allergic or idiosyncratic reactions. This response develops as a rule, in patients who have had only 1-4 doses of meprobamate and have not had a previous contact with the drug. Previous history of allergy may or may not be related to the incidence of reactions.

Mild reactions are characterized by an itchy urticarial or erythematous, maculopapular rash which may be generalized or confined to the groin. Acute nonthrombocytopenic purpura with cutaneous petechiae, ecchymoses, peripheral edema, and fever have also been reported.

More severe cases, observed only very rarely, may also have other allergic responses, including fever, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anaphylaxis, stomatitis and proctitis (1 case), and hyperthermia. Treatment should be symptomatic such as administration of epinephrine, antihistamine, and possibly hydrocortisone. Meprobamate should be stopped, and reinstitution of therapy should not be attempted.

Rare cases have been reported where patients receiving meprobamate suffered from aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis, and hemolytic anemia. In nearly every instance reported, other toxic agents known to have caused these conditions have been associated with meprobamate. A few cases of leukopenia during

continuous administration of meprobamate are reported, most of these returned to normal without discontinuation of the drug.

Impairment of accommodation and visual acuity has been reported rarely.

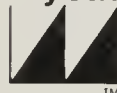
OVERDOSE: Two instances of accidental or intentional significant overdosage with ethoheptazine citrate combined with aspirin have been reported. These were accompanied by symptoms of CNS depression, including drowsiness and light-headedness, with uneventful recovery. However, on the basis of pharmacological data, it may be anticipated that CNS stimulation could occur. Other anticipated symptoms would include nausea and vomiting. Appropriate therapy of signs and symptoms as they appear is the only recommendation possible at this time. Overdosage with ethoheptazine combined with aspirin would probably produce the usual symptoms and signs of salicylate intoxication. Observation and treatment should include induced vomiting or gastric lavage, specific parenteral electrolyte therapy for ketoacidosis and dehydration, watching for evidence of hemorrhagic manifestations due to hypoprothrombinemia which, if it occurs, usually requires whole-blood transfusions.

DESCRIPTION: Each Equagesic tablet contains 150 mg meprobamate, 75 mg ethoheptazine citrate and 250 mg aspirin.

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*This drug has been evaluated as possibly effective for this indication.

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FOR MODERATE PAIN

A therapeutic dose
of acetaminophen
in *one* tablet

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of two complementary
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The convenience and
economy of a
dosage schedule of
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hours as needed



WHY NOT WYGESIC®^{IV}

(65 mg propoxyphene HCl and 650 mg acetaminophen) Wyeth

WYGESIC—Abbreviated Summary

INDICATION: For the relief of mild-to-moderate pain.
CONTRAINDICATION: Hypersensitivity to propoxyphene or to acetaminophen.

WARNINGS: CNS ADDITIVE EFFECTS AND OVERDOSE: Propoxyphene in combination with alcohol, tranquilizers, sedative-hypnotics, or other CNS depressants has an additive depressant effect. Patients taking this drug should be advised of the additive effect and warned not to exceed the dosage recommended. Toxic effects and fatalities have occurred following overdoses of propoxyphene alone or in combination with other CNS depressants. Most of these patients had histories of emotional disturbances or suicidal ideation or attempts, as well as misuse of tranquilizers, alcohol, or other CNS-active drugs. Caution should be exercised in prescribing large amounts of propoxyphene for such patients (see **Management of Overdose**).

DRUG DEPENDENCE: Propoxyphene can produce drug dependence characterized by psychic dependence and less frequently, physical dependence and tolerance. It will only partially suppress the withdrawal syndrome in individuals physically dependent on morphine or other narcotics. The abuse liability of propoxyphene is qualitatively similar to codeine's although quantitatively less, and propoxyphene should be prescribed with the same degree of caution appropriate to the use of codeine.

USAGE IN AMBULATORY PATIENTS: Propoxyphene may impair the mental and/or physical abilities required for potentially hazardous tasks, e.g. driving a car or operating machinery. Patients should be cautioned accordingly.

USAGE IN PREGNANCY: Safe use in pregnancy has not been established relative to possible adverse effects on fetal development. **INSTANCES OF WITHDRAWAL SYMPTOMS IN THE NEONATE HAVE BEEN REPORTED FOLLOWING USAGE DURING PREGNANCY.** Therefore, propoxyphene should not be used in pregnant women unless, in the

judgement of the physician, the potential benefits outweigh the possible hazards.

USAGE IN CHILDREN: Propoxyphene is not recommended for children because documented clinical experience has been insufficient to establish safety and a suitable dosage regimen in the pediatric group.

PRECAUTIONS: Confusion, anxiety, and tremors have been reported in a few patients receiving propoxyphene concomitantly with orphenadrine. The CNS depressant effect of propoxyphene may be additive with other CNS depressants, including alcohol.

ADVERSE REACTIONS: The most frequent adverse reactions are dizziness, sedation, nausea, and vomiting. These seem more prominent in ambulatory than in nonambulatory patients; some of these reactions may be alleviated if the patient lies down.

Other adverse reactions include constipation, abdominal pain, skin rashes, light-headedness, headache, weakness, euphoria, dysphoria, and minor visual disturbances. The chronic ingestion of propoxyphene in doses over 800 mg per day has caused toxic psychoses and convulsions. Cases of liver dysfunction have been reported.

DRUG INTERACTIONS: Propoxyphene in combination with alcohol, tranquilizers, sedative-hypnotics, and other CNS depressants has an additive depressant effect. Patients taking this drug should be advised of the additive effect and warned not to exceed the dosage recommended. (see **Warnings**) Confusion, anxiety, and tremors have been reported in a few patients receiving propoxyphene concomitantly with orphenadrine.

MANAGEMENT OF OVERDOSE: SYMPTOMS The manifestations of serious overdosage with propoxyphene are similar to those of narcotic overdosage and include respiratory depression (a decrease in respiratory rate and/or tidal volume, Cheyne-Stokes respiration, cyanosis), extreme somnolence progressing to stupor or coma, pupillary constriction, and circulatory collapse. In addition to these characteristics, which are reversed by narcotic antago-

nists such as naloxone, there may be other effects. Overdoses of propoxyphene can cause delay of cardiac conduction as well as focal or generalized convulsions, a prominent feature in most cases of severe poisoning. Cardiac arrhythmias and pulmonary edema have occasionally been reported, and apnea, cardiac arrest, and death have occurred.

Symptoms of massive overdosage with acetaminophen may include nausea, vomiting, anorexia, and abdominal pain, beginning shortly after ingestion and lasting for 12 to 24 hours. However, early recognition may be difficult since early symptoms may be mild and nonspecific. Evidence of liver damage is usually delayed. After the initial symptoms, the patient may feel less ill, however, laboratory determinations are likely to show a rapid rise in liver enzymes and bilirubin. In case of serious hepatotoxicity, jaundice, coagulation defects, hypoglycemia, encephalopathy, coma, and death may follow. Renal failure due to tubular necrosis, and myocardiopathy, have also been reported.

Ingestion of 10 grams or more of acetaminophen may produce hepatotoxicity. A 13-gram dose has reportedly been fatal.

TREATMENT: Primary attention should be given to the reestablishment of adequate respiratory exchange through provision of a patent airway and institution of assisted or controlled ventilation. The narcotic antagonists, naloxone, nalorphine, and levallorphan, are specific antidotes against the respiratory depression produced by propoxyphene. An appropriate dose of one of these antagonists should be administered, preferably IV, simultaneously with efforts at respiratory resuscitation and the antagonist should be repeated as necessary until the patient's condition remains satisfactory. In addition to a narcotic antagonist, the patient may require careful titration with an anticonvulsant to control seizures. Analeptic drugs (e.g. caffeine or amphetamine) should not be used because of their tendency to precipitate convulsions.

Oxygen, IV fluids, vasopressors and other supportive measures should be used as indicated. Gastric lavage may be helpful. Activated charcoal can absorb a significant amount of ingested propoxyphene. Dialysis is of little value in poisoning by propoxyphene alone. Acetaminophen is rapidly absorbed, and efforts to remove the drug from the body should not be delayed. Copious gastric lavage and/or induction of emesis may be indicated. Activated charcoal is probably ineffective unless administered almost immediately after acetaminophen ingestion. Neither forced diuresis nor hemodialysis appears to be effective in removing acetaminophen. Since acetaminophen in overdose may have an antidiuretic effect and may produce renal damage, administration of fluids should be carefully monitored to avoid overload. It has been reported that mercaptamine (cysteine) or other thiol compounds may protect against liver damage if given soon after overdosage (8-10 hours). N-acetylcysteine is under investigation as a less toxic alternative to mercaptamine, which may cause anorexia, nausea, vomiting, and drowsiness. Appropriate literature should be consulted for further information (JAMA 237:2406-2407, 1977).

Clinical and laboratory evidence of hepatotoxicity may be delayed up to one week. Acetaminophen plasma levels and half-life may be useful in assessing the likelihood of hepatotoxicity. Serial hepatic enzyme determinations are also recommended.

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MATERNAL HEALTH DESK REFERENCE CARD NO. 24

(Sponsored and Prepared by the Committee on Maternal and Perinatal Health, Michigan State Medical Society)

ULTRASOUND

I. Introduction

Diagnostic ultrasound can often be a helpful examination in obstetrics. *The use of ultrasound should remain a special examination and not be considered a routine part of prenatal care.*

II. Obstretic Indications (Ultrasound is an aid in the diagnosis or corroboration of the following):

- A. Early Pregnancy
 - Confirmation of pregnancy (after 6 weeks)
 - Detection of extrauterine pregnancy
 - Investigation of abortion
 - Retained products of conception
 - Hydatidiform mole
 - Confirm fetal life (realtime)
 - Associated pelvic tumors
 - Determine gestational age
 - Confirm and the presence of IUCD within the uterus
 - Aid to the early diagnosis of multiple pregnancy
- B. Middle and Late Pregnancy
 - Fetal growth rate
 - Maturity
 - Multiple pregnancy
 - Aid in amniocentesis
 - Hydramnios
 - Placental localization
 - Placental development
 - Fetal anomaly
 - Fetal death
 - Presentation
- C. Puerperium
 - Retained products
 - Hematoma
 - Abscess
 - Associated tumors

III. Patient Preparation

- A. Satisfactory ultrasound examination of the pelvis requires that the urinary bladder be distended, and the use of an acoustically conductive medium on the abdominal wall to ensure effective contact with the ultrasound transducer. (Bladder distention can be accomplished by the ingestion of 24-32 oz. of fluid 45-60 minutes before the examination.)

IV. Conditions which interfere with ultrasound examination

- A. Failure to obtain a full urinary bladder
- B. Excessive gas or Barium within the intestine interferes with transmission of the ultrasound beam.
- C. Abdominal dressings over the area of interest precludes satisfactory transducer skin contact.

(continued on other side)

V. Limitations of Ultrasound

- A. Fetal sex cannot be reliably determined.
- B. An extrauterine IUCD usually cannot be accurately located.
- C. In a collection of fluid, abscess cannot be distinguished from hematoma.
- D. Estimation of fetal age is most accurate by measurement of Crown-rump length between 8 and 13 weeks or biparietal diameter between 13 and 26 weeks gestation
- E. Many fetal anomalies cannot be detected.
- F. Ultrasound does not replace biochemical and other tests for fetal maturity.

VI. Additional Comments

- A. The long term effect of ultrasound examination on the fetus cannot be accurately predicted at this time.
- B. Updated, well-maintained equipment is recommended.
- C. Special training is advised for physicians administering the ultrasound examination.

This reference card prepared by R.W. Postmus, MD, June, 1980.

Research, improved care lowering Reye's Syndrome death rate

By Martha Smith, Special to Michigan Medicine

Since Reye's Syndrome was first acknowledged by the medical profession in 1963, researchers have found many victims of Reye's are previous victims of the viral diseases influenza A, B, and the chicken pox.

State-wide surveillance of this sometimes fatal disease began in 1974 to determine the validity of this relationship and gain more information.

That year, 75 percent of the Reye's cases in the nation were in states bordering on the Great Lakes, with 11 per cent of these cases in Michigan. Because of this Reye's is also referred to as the "Great Lakes" disease.

During a Type B influenza outbreak between Jan. 1 and April 13 of that year, 28 counties in most rural areas reported and confirmed 46 cases of Reye's Syndrome. These Reye's cases reflected the distribution of influenza with respect to age, date of onset and location.

Statistics indicate that Reye's syndrome usually occurs one to 10 days after onset of an acute viral disease and victimizes infants to 18-year-olds. Overall, however, Reye's strikes only a small percentage of children with influenza and chicken pox.

Peak ages

According to Edgardo Arcinue, MD, director of Detroit Children's Hospital's Reye's Syndrome Study Center, the disease peaks twice, at ages 6 to 8 and again at 11 to 21. Experts active in researching Reye's Syndrome hypothesize that the non-contagious disease usually does not strike inner-city youngsters because many of them have already contacted flu or chicken pox by the time they reach school age.

Within a few weeks, 50 to 70 percent of typical cases recover fully. About 10 percent suffer permanent brain damage and 20 to 30 percent die.

The high percentage of typical



cases resulting in death has led to increased medical research and community concern. The public's misinterpretation of these facts, publicized by the news media, have produced panic situations resulting in an influx of patients seeking doctors' help. This situation is experienced by a number of physicians during peak influenza periods.

Due to sophisticated surveillance and greater public awareness, Reye's Syndrome is recognized as a prominent and reoccurring disease here in Michigan. This also may account for Michigan's high incident rate.

Presently, it is this "awareness" that may serve as a key to preventing or otherwise minimizing the effects of Reye's Syndrome.

According to Norman Hayner, MD, chief, Division of Epidemiology

for the Michigan Department of Public Health (MDPH), it is difficult to speculate whether or not Michigan will be subject to future outbreaks of Reye's Syndrome.

In the past, Reye's cases have corresponded to the influenza period, thus making mid-December a likely month for physicians to expect cases to appear.

The MDPH reports that since Jan. 1 of this year, 69 children in 33 counties developed probable or suspect cases of Reye's Syndrome. Five of these youngsters died. Again, these cases correspond to this year's influenza outbreak, and reinforce the existing data on their suspected relationship.

In June 1977, Maurice Reizen, MD, MDPH director, appointed a Reye's Syndrome Task Force to coor-

REYE'S SYNDROME/continued

dinate and guide health agencies coping with cases of Reye's.

Disease studies

Epidemiological investigations also have compared cases and victims' families with controls to examine possible relationships of environmental toxins or familial factors. Other causative theories under investigation are dietary toxins, immune systems defects, and inherited bio-chemical disorders.

A University of Michigan doctoral thesis being done by Fee A.B. Luscombe,¹ involves a study on epidemiologically-related deaths of children in Michigan over an eight and a half year period. Evidence in the investigation supports the impression that deaths attributed to encephalitis and encephalopathy probably were due to Reye's instead. This study is complicated by the lack of a unique rubric for Reye's Syndrome, which gives this investigation such importance.

A new collaborative study developed in Crawford-Au Sable School District examines influenza's relationship to Reye's Syndrome. This study is to determine whether influenza A and/or B are common

concurrents of stage "O" Reye's cases (i.e., one that does not involve neurological symptoms).

After an influenza outbreak, two serum specimens were obtained from approximately 1,100 students participating in the study, to ascertain unusual increases in the serum glutamic pyruvic transaminase (SGPT) levels. Sixteen students tested showed an increase in SGPT levels. Results indicate the distinct possibility that a "forme fruste" of Reye's may occur in children with influenza much more frequently than outright Reye's Syndrome. This possibility is under further investigation.

Symptoms studies

In addition to research on these diseases' relationships, studies also are being done on symptoms characteristic of Reye's Syndrome.

A transient fatty degeneration of liver cells and a rise in liver enzymes are two such symptoms. Although the specific causes have not been determined, these symptoms have been helpful in identifying Reye's victims.

The serum glutamic oxaloacetic transaminase (SGOT) blood test, which registers increased levels of liver enzymes, has proven to be a quick, inexpensive and efficient procedure for warning physicians that stage "O" Reye's may exist and that

more critical stages may develop. Liver biopsies have been used to confirm diagnosis of Reye's in its more critical stages.

According to Doctor Hayner, a consistent liver biopsy of the findings of two of the following three abnormalities is considered sufficient to support diagnosis of Reye's Syndrome: (1) Elevation of either or both SGOT or SGPT to more than twice the upper limit of normal. (2) Elevation of serum ammonia, and (3) Prolongation of the prothrombin time (at least two seconds more than the control; i.e., about 50 per cent or less).

Present situation

Currently, doctors are administering a number of procedures to reduce cranial pressure and maintain patients' respiratory functions. These procedures have met with qualifying success and many have been abandoned.

The present situation of this health problem has been recognized by Michigan legislators as well as local governments. In an effort to support the medical profession, Raymond Hood, chairman, House Public Health Committee, was appointed chairman of a Subcommittee on Reye's Syndrome. A thorough report on the status of the disease may substantiate the allocation of government funds for further research.

Efforts made over the past decade have resulted in a decrease in the case fatality rate from 40 percent in 1969 to 25 percent in 1979 for the two hospitals most likely to receive critical cases. It is estimated Michigan spent \$1,000,000 on acute care, detection, and associated costs related to the 90 cases of Reye's that occurred in 1979. Areas where various improvements are being considered are in transportation of critical cases and additions of pediatric intensive care units in Northern Michigan.

Researchers hope improvements in these areas, along with promising research results, will continue to decrease the number of fatal cases, so few youngsters experience Reye's Syndrome in the future.

FOOTNOTE

¹ University of Michigan doctoral thesis: *A Retrospective Epidemiological Study of Reye's Syndrome in Michigan*, by Fee A.B. Luscombe, 1978.

Michigan Cancer Foundation cells used in interferon research

Human cells isolated and first grown in Detroit are being used around the world in laboratories where interferon is being studied as a "biological response modifier" that might be less toxic than chemotherapy in cancer treatment.

Called MCF-7, the cell line was isolated at the Michigan Cancer Foundation, in 1974. Many scientists evaluating interferon are using the MCF-7 line as a standard cell.

Of the 10 US facilities conducting controlled clinical testing with interferon, two centers also are using the MCF-7 cell; the University of Texas M.D. Anderson Hospital and Tumor Institute and the Sloan Kettering Institute for Cancer Research in New York. An English scientist, Doctor Joyce Taylor-Papadimitriou of the Imperial Cancer Research Fund in

London, also is studying interferon using cells from the Michigan Cancer Foundation.

The use of MCF-7 cells as a standard enables scientists to examine the way interferon acts upon a living cell — a process scientists call studying the "mechanisms" of action. In addition to their use in interferon studies, MCF-7 cells are used by scientists at more than 100 research centers in various U.S. facilities, in Australia, Japan, Russia and Europe.

In another research program related to interferon, Cancer Foundation scientists are studying the ability of interferon to change the course of leukemia.

The Michigan Cancer Foundation is a Torch Drive/United Way agency.

The primary beneficiaries of ORAL HYDERGINE® TABLETS, 1 mg (1 tab t.i.d.)

Each 1 mg Hydergine tablet contains dihydroergocornine mesylate 0.333 mg, dihydroergocristine mesylate 0.333 mg, and dihydroergocryptine (dihydro-alpha-ergocryptine and dihydro-beta-ergocryptine in the proportion of 2:1) mesylate 0.333 mg, representing a total of 1 mg.

They're in their late sixties, the beneficiaries of more liberal retirement laws and more enlightened attitudes toward the elderly. They're leading socially productive lives. But recently, without any clear cause, they had each begun to experience mild episodes of symptoms such as confusion, mood-depression, and dizziness. Their ability to function could have been jeopardized. That's when they became the beneficiaries of oral Hydergine therapy.



The still-functioning geriatric can benefit from Hydergine treatment

It is quite common for cognitive and emotional symptoms of deterioration to manifest gradually in the elderly. During this early stage, such symptoms are mild and more amenable to treatment. It is at this stage that Hydergine therapy has proved most effective. Patients tend to respond better, and with symptoms effectively relieved—or at least their progression retarded—the ability to function can be maintained.

Oral Hydergine tablets promote better patient compliance

Compared with the sublingual form, dosage administration is easier, with less need for supervision.

Contraindications: Hypersensitivity to the drug.

Precautions: Because the target symptoms are of unknown etiology, careful diagnosis should be attempted before prescribing Hydergine tablets and sublingual tablets.

Adverse Reactions: Serious side effects have not been found. Some sublingual irritation, transient nausea, and gastric disturbances have been reported. Hydergine tablets and sublingual tablets do not possess the vasoconstrictor properties of natural ergot alkaloids.

Dosage and Administration: 1 mg three times daily. Alleviation of symptoms is usually gradual and results may not be observed for 3–4 weeks.

How Supplied: Hydergine tablets (for oral use) 1 mg, packages of 100 and 500. Hydergine sublingual tablets 1 mg, containing dihydroergocornine mesylate 0.333 mg, dihydroergocristine mesylate 0.333 mg, and dihydroergocryptine (dihydro-alpha-ergocryptine and dihydro-beta-ergocryptine in the proportion of 2:1) mesylate 0.333 mg, representing a total of 1 mg; packages of 100, 500, and 1000. Hydergine sublingual tablets 0.5 mg, containing dihydroergocornine mesylate 0.167 mg, dihydroergocristine mesylate 0.167 mg, and dihydroergocryptine (dihydro-alpha-ergocryptine and dihydro-beta-ergocryptine in the proportion of 2:1) mesylate 0.167 mg, representing a total of 0.5 mg; packages of 100 and 1000.

Before prescribing, see package insert for full product information.

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Females may surpass males in endurance athletic events



Edwin R. Guise, MD, left, chairman, MSMS Sports Medicine Conference, is interviewed by Lansing television reporter Rusty Hills.

The public's growing awareness of physical fitness was evident in the topics of the Michigan State Medical Society's 14th annual Sports Medicine Conference, April 10 at Long's Convention Center, Lansing.

The major objective of this conference is to offer physicians an opportunity to receive CME Category I credits by learning how to recognize and diagnose sports-related injuries and also what specialists recommend for treating them. In addition to physicians, program participants also included trainers, coaches, and athletes.

Emphasis at the 1980 event was placed on injuries suffered not only by professional athletes but also by persons participating in athletics on a recreational basis. This allowed participants to receive practical and useful instruction in conservative treatment of minor injuries suffered

in popular activities such as jogging, tennis, or swimming.

Athletics' role

The program underscored the role athletics plays in today's society and will play in the future.

After an initial greeting from convention chairman Edwin Guise, MD, the day long program opened with speaker Rose Snyder, Certified Athletic Trainer from the Center for Athletic Medicine at Henry Ford Hospital.

Ms. Snyder discussed the potential women have for being disciplined and successful athletes, and stated, "Women should be recognized as athletes in their own right, and not as scaled-down versions of their male counter-parts."

According to the most current studies in training, physiological responses, and incidence of injuries,

women athletes, Ms. Snyder said show the same gains and response to similar training techniques as male athletes.

With the exception of upper body strength, research indicates there are no physiological differences in the sexes which would inhibit a woman's performance or make her more prone to a specific injury, she said. Theoretically, due to the increased proportion of body fat in females, women may be equal to, or even surpass, achievements of males in long distance endurance events.

The program continued with insights from Mike Kittleson, weight training coach for the University of Michigan, on current trends in weight lifting. Mr. Kittleson emphasized the need for training programs which exercise not only major, but also minor muscles of the body to reduce the risk of injury. There are new exercise machines being introduced which will allow conditioning of such muscles, particularly in the legs, he said.

"The often-neglected trunk area of the body should also receive more attention," said Mr. Kittleson. Systems used in his training programs also were discussed, such as the method he terms "intensity overload," which works on the principle of decreasing weight while increasing repetitions.

Tennis injuries

An area of concern and interest to the public today was discussed by Neal Marcus, MD, orthopedic surgery, Henry Ford Hospital, who spoke on tennis injuries. Doctor Marcus discussed ruptured plantaris muscles, a leg injury most prevalent in players 40 years and older, and said it is usually due to repeated short, side-to-side motion. He recommended conservative treatment including rest, ice, stretching, com-



Ms. Snyder

pression of the calf, ultra-sound treatments, and heel lifts in shoes.

The most common injury Doctor Marcus noted is tennis elbow, which he said is caused by muscle over-load. This inflammation of the elbow, which may or may not involve a rupture, is most prevalent in 35- to 50-year-old, white players.

Increased playing time, continuous backboard practice, or improper equipment may create such a condition, he said, but most often it is aggravated by a backhand swing that incorporates a "leading elbow." He said it is important for players to swing the racket from the shoulder, with proper weight transfer. A player also may be encouraged to develop a two-handed backhand, or to consider using a lighter, more flexible racket or a different grip.

Doctor Marcus recommended treatment that includes rest, local or systemic medication, braces, and possibly surgery if symptoms persist for over a year. Doctor Marcus speculates that with an increasing number of junior tennis players, youthful tennis elbow, also classified as "little leaguer's elbow" also will rise.

Running injuries

The morning session concluded with a discussion on the medical problems of competitive runners and garden variety joggers by Robert Teitge, MD, of Stanford University's Sports Medicine Clinic. (As of May 1 Doctor Teitge will be the newly appointed director of the Center for

The Staff of Aesculapius

(After the Manner of Kahlil Gibran.)

The following verse was written by John R. Rodger, MD, Bellaire. Doctor Rodger wrote the verse in 1932 when he was a junior in the University of Michigan Medical School. He now is a retired family physician after practicing for 43 years.

The verse so nicely presents the idealism of the dedicated physician. It is printed here with hopes it will re-inspire and renew practicing physicians across the state.

AND a Physician said, Speak to us of Healing. And the Prophet answered and said:

You heal, not for fees nor self-sought places of esteem, but in urge to that deep spring of love within the heart of every man.

Before you await the gifts of knowledge and of skill, that your love may flow in well-trenched brooks, nor be submerged within the sand;

Therefore weary not in your striving for knowledge of your art and sureness of your eye and hand.

For that which to you now seems useless, tomorrow is the foundation stone of your Temple;

And in that Temple may you be a true Priest of your Faith, with tireless energy for days of loving service which know not hours of entrance nor of end,

With patience which allows no irritance, and hope which admits no defeat

Remember, Oh Physician, that the ills of mind and body balance the scales of suffering with fevered wound and broken body;

Therefore look you to the whole man, as well as to that part of him you see and touch.

For the help you best can give him may speak more of sunsets and of love of neighbors than of surgeon's knife or apothecary's draught.

And may the Art of Healing never hide from you the one you heal, nor lose for you the sufferer within the sea he struggles in,

But may your every gift call out the peak-thrust of your effort, and be given him who calls for it as if to your beloved;

For in the Wards of God there is neither race nor creed nor caste, but only pain-afflicted children with arms out-thrust to seek His soothing mercy from your hands.

ANN ARBOR, MICH.

— JOHN R. RODGER
U. of M. Medic., '33.

Athletic Medicine at Henry Ford Hospital.)

Doctor Teitge first discussed microtraumatic syndromes of the lower extremities due to repetitive stress. This stress or over-load may be attributed to an increase in mileage, a change in routine, fatigue, or a low tolerance due to poor body design. Common to many runners are shin spints and heel spurs, which may occur due to such strain. Stretching and consciousness of over-load help to prevent these injuries. Ice, rest, and creating a softer running surface are suggested treatments.

Doctor Teitge also discussed foot pronation as necessary and normal to allow the foot to absorb shock. However, he did say that excessive pronation could result in injury to the foot.

Other subjects dealt with during the afternoon session included the prevention, protection, and recognition of head and neck injuries, rehabilitation of high school athletes, swimmer's shoulder, and recognition and diagnosis of knee joint difficulties.

MSMS Annual Scientific Meeting Nov. 18-19-20 at Hyatt Regency Dearborn

A comprehensive array of Category I CME courses is being arranged for the selection of Michigan physicians attending the 1980 MSMS Annual Scientific Meeting.

The Annual Scientific Meeting, one of the largest state society-sponsored CME programs in the country, is planned Nov. 18-20 at the Hyatt Regency Dearborn.

A total of 18 Category I credits will be available to Michigan physicians choosing from the 56 individual courses now in preparation.

The courses will run half-days from 8:30 to noon and from 1:30 to 5 p.m. Tuesday, Wednesday and Thursday. Courses will be located close together in one wing of the glittering convention-hotel facility.

Samuel M. McMahon, MD, Lansing, Annual Scientific Meeting chairman for the second year, and his advisory committee have worked with virtually every major Michigan medical specialty group to arrange courses.

Subjects have been chosen to help the practicing physician in day-to-day work. Most courses will award prescribed recertification credits to family physicians.

New courses

Some new approaches are being taken to the courses this year.

At least three of the sessions will feature presentations of difficult, unusual or otherwise interesting cases by physicians attending the course. Their cases then will be discussed by

a faculty panel and other physicians attending the course.

The physicians who present these cases for discussion will be drawn from among the early registrants for the Annual Scientific Meeting. Traditionally, one third of the physicians attending the meeting are registered a month in advance, and those selected will be notified at that time.

Several new courses are planned on management of emergency problems — wounds and other injuries.

Several new courses also are planned on dealing with the "whole patient," and the emotional, as well as physical manifestations of certain conditions. Among these courses will be management of emergency psychiatric conditions and helping abortion patients cope with the emotional stress of their decisions.

New combinations of sponsors are collaborating to present full days on a particular subject. For example, the Michigan Orthopedic Society and MSMS Committee on Sports Medicine are planning a full day of courses.

Specialists treating diabetes are planning a half-day course on that disease, then combining with family physicians to present a course on care of the elderly, particularly examining the use of drug therapy.

A full day of psychiatric subjects also is planned.

Non-medical courses which will help physicians better care for their patients include one on implement-

ing CME programs in small hospitals, one on medical-ethical decisions and another on being a better medical expert witness.

The latter will include simulated courtroom situations and testimony.

Fine setting

The 1980 Annual Scientific Meeting facility again is the Hyatt Regency Dearborn, with its 12-story atrium, new wing containing pool and meeting rooms, wide variety of restaurants, one of the few remaining Detroit-area nightclubs, its "people-mover" monorail connections with the Fairlane Shopping Center and proximity to Greenfield Village and Henry Ford Museum.

MSMS again will arrange for coffee breaks, luncheons for course participants, and late-afternoon beer busts, to break up the study time.

A large exhibit hall featuring booths by MSMS, affiliated organizations and 75 commercial exhibitors will be open each day and serve as the scene for the beer busts and MSMS-arranged luncheons.

Again, course registration fees will be nominal, in line with the MSMS policy of charging the lowest possible price for members' CME offerings.

A list of courses will appear in the second June issue of the MSMS Medigram newsletter, with registration forms and complete course information to follow in the September Michigan Medicine, and September and October Medigram.

The Thrill of CME Without the Agony



Continuing Medical Education doesn't have to be agonizing. In fact, it can be downright exciting. You'll thrill to new discoveries as you study alongside 2,000 of your practicing physician colleagues at the 1980 MSMS Annual Scientific Meeting, November 18-20. The beautiful Hyatt Regency Dearborn is the setting

for half-day courses where you can hear medical experts from all around the state and country and earn up to 18 hours of Category I credit. Make plans today!

**MSMS ANNUAL
SCIENTIFIC MEETING**
November 18-19-20, 1980
Hyatt Regency Dearborn



Detroit Medical Society voice of black physicians

By Shelton Reece, Special to Michigan Medicine



Detroit Medical Society officers, from left, William C. Sharp, MD, secretary, George A. Lightbourn, MD, president, and John A. Feemster, MD, vice president. Not shown are Ann Maré Ice, MD, treasurer, and Richard H. Smith, MD, parliamentarian.

The 300-plus member Detroit Medical Society, third largest and one of the oldest predominantly black physician groups in North America, recently received the highest commendation possible from the National Association for the Advancement of Colored People.

The 24th Annual NAACP Fight for Freedom dinner, a large gathering in Detroit's Renaissance Center, was dedicated to the Society.

Initiated in 1957 by Lionel F. Swan, MD, then DMS president, the dinner has grown to be the most lucrative fund-raising event of any in the civil rights movement. Approximately \$400,000 was raised at the dinner in 1979 and the total was higher this year.

"Fight for freedom" could well be the by-words for the 63-year-old DMS which originally was organized under the name Allied Medical Society early in the 20th century.

That was a period of rampant racial segregation in the United States in all aspects of life, including the medical profession. Black patients and doctors were denied equal access to both private and public hospitals in Detroit.

In 1910, Detroit's 10 black physicians, unable to practice in the hospi-

tals, rendered the best care possible in their offices and patients' homes to nearly 6,000 black citizens.

By 1917, with 30,000 blacks in the city, the medical situation approached a crisis stage. The 20 over-worked black physicians no longer could deal with the medical institutions denying access to black patients and doctors.

As a result, they banded together to raise funds to establish a hospital to care for black citizens, and to alleviate discrimination toward black patients and physicians.

Many strides

That the Society accomplished those goals is evident by the many strides that have been made against discrimination (although they believe some still exists) in medical institutions, and the fact that in 1919 it helped to open Dunbar Memorial Hospital — the first black proprietary hospital in Detroit.

Dunbar, later known as Parkside Hospital, along with several other black hospitals, served the needs of black doctors and patients well. However, Dunbar was closed in 1962 when Detroit's Medical Center was activated.

Its closing sparked members of

DMS to begin one of its current projects. When the Society learned that Dunbar was to be demolished, members began raising funds and meeting with Detroit City Council in efforts to save the building.

DMS undertook the mammoth job not only because it recognized the historical importance of the structure to the black community, but also because it saw that the hospital, if refurbished, could fill several vital needs, one of the most important of which was that it could become the first central headquarters for the Society.

Funds were raised and the Council agreed to let DMS save and refurbish the building. A State of Michigan Historical Marker was awarded to the DMS for the Dunbar Building during the 84th National Medical Association Convention and Scientific Assembly in Detroit.

DMS plans to reopen the Dunbar building soon. At that time it will house the Society's and its Auxiliary's offices, provide space for other association headquarters, and will make many activities and services available which earlier were not possible.

According to George A. Lightbourn, MD, DMS president, "With the Dunbar Medical Project located as it is in Detroit's Medical Center, DMS can take a more active part in shaping the future of the area, in particular, and in Detroit's medical community in general.

"With DMS more clearly identified, we will be able to fill the role of a friend-in-need to black medical students, interns, and residents who need advice and support in their pursuit of professional excellence.

"Also, the difficulty of legislators seeking the opinions and assistance of black physicians when making legislative decisions should be more readily resolved when the DMS headquarters office is operative.

"A more visible DMS can provide a valuable resource to assist in the resolution of difficult problems such as drug abuse, teenage pregnancy, and low self-esteem in the educative process in our public schools.

"Additionally, the Black Medical Museum will be housed at the Dunbar Medical Building. This will provide an opportunity to show the evolution of medical practice in De-

troit's black community and offer an opportunity to make a payment on the debt of gratitude that is owed to our resourceful and courageous medical forefathers."

Today's Detroit Medical Society is headed by Doctor Lightbourn; John A. Feemster, MD, vice-president; William C. Sharp, MD, secretary; Ann Mare Ice, MD, treasurer, and Richard H. Smith, MD, parliamentarian.

Career guidance

Among its continuing projects are a Medical Careers Program aimed at giving help and guidance to high school students who are interested in pursuing health care careers. DMS members began this project during the 1960's in conjunction with the Michigan Health Council. They went into high schools and helped establish Health Careers Clubs. Their activities have been commended and backed by the Detroit Board of Education and plans call for continuing and expanding the project.

Another endeavor is an active recruitment drive to offer the opportunity to all black physicians in the area — both medical and osteopathic — to become members of the Society.

"We know there are many, perhaps 500 or so, black and minority physicians in Greater Detroit who are not yet members of DMS," Dr. Lightbourn says.

"We want those doctors and medical students to become members not just to increase the size of the organization, but to help us, and themselves offer the best health care possible to anyone who needs it, when it is needed.

"One of the many ways in which we can accomplish that is for black physicians to become a part of our society, as well as other professional groups and to become more active participants in more areas where decisions are made.

"We've all seen what can happen when many physicians and organizations work together for, or against something. Here I'm talking about the recent bed cutting efforts of the CHPC. Collective efforts by physicians and other groups, once again, proved there certainly is strength in numbers . . . particularly if those numbers make their position known unmistakably.



A photograph taken in 1922 of some of the founding members of today's Detroit Medical Society, along with members of Dunbar Hospital staff of that day.

"Black physicians, especially those practicing in urban areas, must become more vocal and must occupy posts in more organizations concerned with the future of health care, because there are many things that affect black physicians which do not affect white ones."

Strategic positions

"Yes, we are represented on committees within the Wayne County Medical Society and Michigan State Medical Society, as well as other fine groups. But most often black physicians there are not in strategic decision-making positions where our participation might be most effective.

"Groups such as DMS should be consulted before black physicians are appointed to important committees.

"On issues such as cutting payments of Medicare and cutting beds from hospitals, the easiest place for bureaucrats to begin is in poor urban areas.

"With a foothold there, they can spread out readily to more affluent areas.

"These, and other such bureaucratic efforts, simply are steps toward the control of medical practice in this country. If left unchecked, they will,

in time, drastically change the practice of medicine as we know it today.

"Make no mistake about it, what happens on these and other important issues in the city will eventually affect our brothers in the suburbs and later our cousins in rural areas.

"The place to stop such things is where they begin, the time to stop them is at their beginning, and the people to listen to are those who are being most affected.

"Perhaps as DMS becomes larger and better recognized as the voice of most black physicians, we can more readily assist those who sincerely want to make the best possible health care, at the lowest possible cost, available to all, regardless of their race or color."

Motrin[®] vs codeine...

ibuprofen



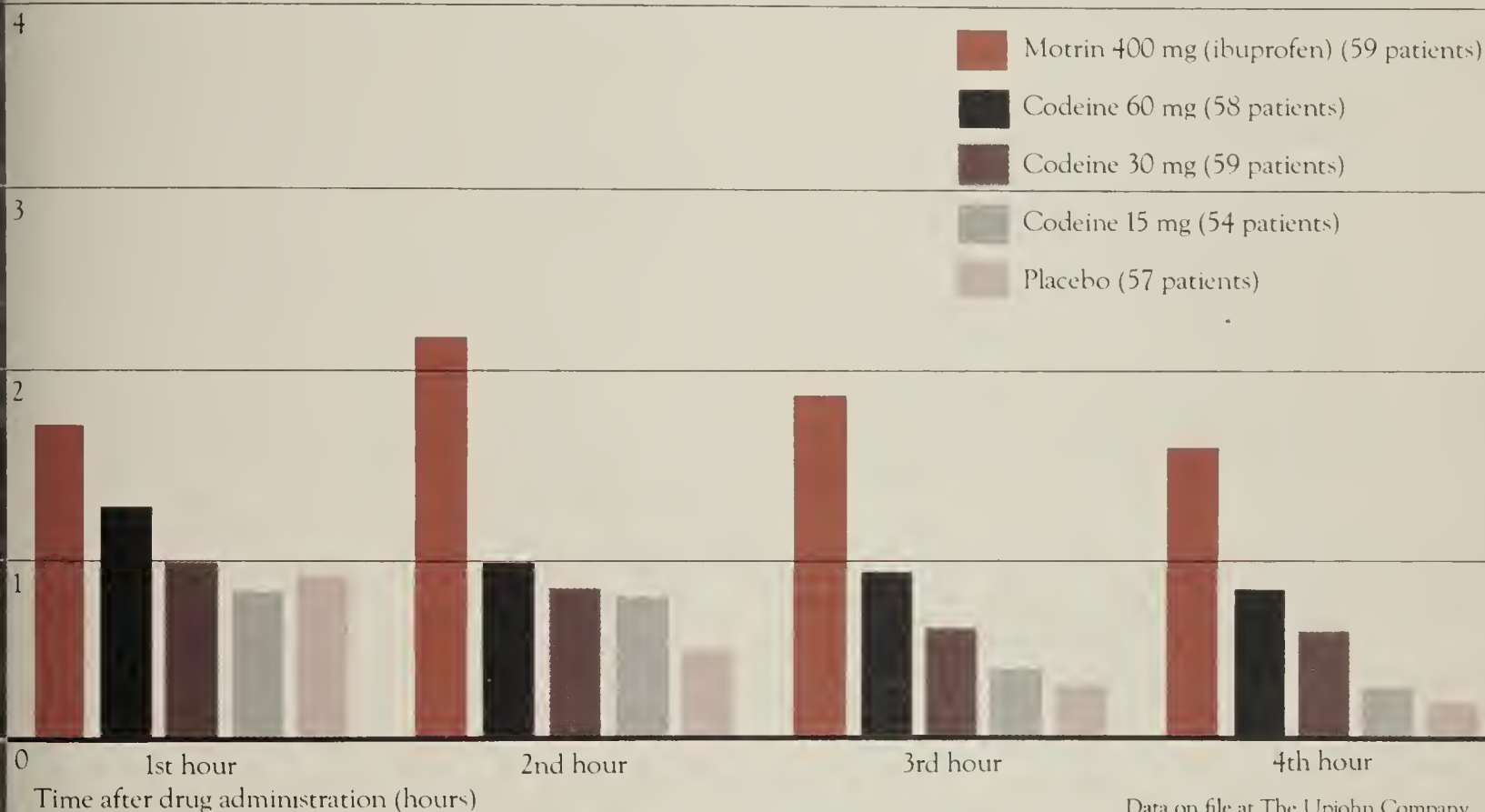
compare the analgesic effect

Motrin (ibuprofen) 400 mg tablets provided greater relief of pain than codeine in a double-blind, randomized clinical study of 287 patients.

Motrin was significantly more effective ($p < 0.01$) than codeine 60 mg at the 2-, 3- and 4-hour intervals...significantly more effective ($p < 0.01$) than codeine 30 mg, codeine 15 mg, and placebo at all intervals.

Degree of pain relief—mean scores

4 = Excellent relief 3 = Good relief 2 = Fair relief 1 = Poor relief 0 = No relief



One tablet q4-6h prn pain

A well-tolerated, nonnarcotic prescription for mild to moderate pain

Motrin[®] 400mg TABLETS
ibuprofen, Upjohn

- Not a narcotic • Not addictive • Not habit forming • Acts peripherally
- Relieves pain rapidly • Indicated in acute and chronic pain • Well tolerated
- The most common side effect with Motrin is mild gastrointestinal disturbance.

Please turn the page for a brief summary of prescribing information.

Upjohn

Motrin[®] (ibuprofen)

now proved an effective analgesic for mild to moderate pain

Motrin[®] Tablets (ibuprofen, Upjohn)

Indications and Usage: Relief of mild to moderate pain.

Treatment of signs and symptoms of rheumatoid arthritis and osteoarthritis during acute flares and in long-term management. Safety and efficacy have not been established in Functional Class IV rheumatoid arthritis.

Contraindications: Individuals hypersensitive to it, or with the syndrome of nasal polyps, angioedema and bronchospastic reactivity to aspirin or other nonsteroidal anti-inflammatory agents (see WARNINGS).

Warnings: Anaphylactoid reactions have occurred in patients with aspirin hypersensitivity (see CONTRAINDICATIONS).

Peptic ulceration and gastrointestinal bleeding, sometimes severe, have been reported. Ulceration, perforation, and bleeding may end fatally. An association has not been established. Motrin should be given under close supervision to patients with a history of upper gastrointestinal tract disease, only after consulting ADVERSE REACTIONS.

In patients with active peptic ulcer and active rheumatoid arthritis, nonulcerogenic drugs, such as gold, should be tried. If Motrin must be given, the patient should be under close supervision for signs of ulcer perforation or gastrointestinal bleeding.

Precautions: Blurred and/or diminished vision, scotomata, and/or changes in color vision have been reported. If these develop, discontinue Motrin and the patient should have an ophthalmologic examination, including central visual fields.

Fluid retention and edema have been associated with Motrin; use with caution in patients with a history of cardiac decompensation.

Motrin can inhibit platelet aggregation and prolong bleeding time. Use with caution in persons with intrinsic coagulation defects and those on anticoagulant therapy.

Patients should report signs or symptoms of gastrointestinal ulceration or bleeding, blurred vision or other eye symptoms, skin rash, weight gain, or edema.

To avoid exacerbation of disease or adrenal insufficiency, patients on prolonged corticosteroid therapy should have therapy tapered slowly when Motrin is added.

Drug interactions. Aspirin used concomitantly may decrease Motrin blood levels. Coumarin: Bleeding has been reported in patients taking Motrin and coumarin.

Pregnancy and nursing mothers: Motrin should not be taken during pregnancy or by nursing mothers.

Adverse Reactions

Incidence greater than 1%

Gastrointestinal: The most frequent type of adverse reaction occurring with Motrin is gastrointestinal (4% to 16%). This includes nausea,* epigastric pain,* heartburn,* diarrhea, abdominal distress, nausea and vomiting, indigestion, constipation, abdominal cramps or pain, fullness of the GI tract (bloating and flatulence). **Central Nervous System:** Dizziness,* headache, nervousness. **Dermatologic:** Rash* (including maculopapular type), pruritus. **Special Senses:** Tinnitus. **Metabolic:** Decreased appetite, edema, fluid retention. Fluid retention generally responds promptly to drug discontinuation (see PRECAUTIONS).

*Incidence 3% to 9%.

Incidence less than 1 in 100

Gastrointestinal: Upper GI ulcer with bleeding and/or perforation, hemorrhage, melena. **Central Nervous System:** Depression, insomnia. **Dermatologic:** Vesiculobullous eruptions, urticaria, erythema multiforme. **Cardiovascular:** Congestive heart failure in patients with marginal cardiac function, elevated blood pressure. **Special Senses:** Amblyopia (see PRECAUTIONS). **Hematologic:** Leukopenia, decreased hemoglobin and hematocrit.

Causal relationship unknown

Gastrointestinal: Hepatitis, jaundice, abnormal liver function. **Central Nervous System:** Paresthesias, hallucinations, dream abnormalities. **Dermatologic:** Alopecia, Stevens-Johnson syndrome. **Special Senses:** Conjunctivitis, diplopia, optic neuritis. **Hematologic:** Hemolytic anemia, thrombocytopenia, granulocytopenia, bleeding episodes. **Allergic:** Fever, serum sickness, lupus erythematosus syndrome. **Endocrine:** Gynecomastia, hypoglycemia. **Cardiovascular:** Arrhythmias. **Renal:** Decreased creatinine clearance, polyuria, azotemia.

Overdosage: In cases of acute overdosage, the stomach should be emptied. The drug is acidic and excreted in the urine, so alkaline diuresis may be beneficial.

Dosage and Administration: Rheumatoid arthritis and osteoarthritis, including flares of chronic disease: Suggested dosage is 300, 400 or 600 mg t.i.d. or q.i.d. Mild to moderate pain: 400 mg every 4 to 6 hours as necessary for relief of pain.

Do not exceed 2400 mg per day.

Caution: Federal law prohibits dispensing without prescription.

For additional product information, see your Upjohn representative or consult the package insert.

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MED B-4-S

PEER REVIEW EXCHANGE

PSRO vitality depends on MD support

By Daniel J. Fall, MD, Ann Arbor

Since the time of its inception, the PSRO program has been enveloped in controversy and plagued by complications.

While critics outside the medical profession maintain the program was a ludicrous concession to physicians, medicine itself was deeply divided over the implications of cooperating with the federal government in such a program.

However, as the 1970s came to an end, the image of the PSRO program began to improve in the eyes of many physician groups. The real latitude and power offered by active physician involvement is being realized in many medical communities across the nation.

Additionally, in these devastatingly difficult financial times, the federal government has increased the PSRO budget by over 30 percent, or \$48 million. Now is the time for physicians to recognize the need to support their colleagues, and develop a better understanding of the program.

PSROs will:

- Assure that all hospitals in their areas provide a comparable basic standard of care to Medicare and Medicaid patients — and, theoretically, to all patients. In the face of mounting federal efforts to restrain costs, PSROs serve a vital public interest by protecting patients from unwarranted restrictions on services.

- Assure that all physicians are not regulated, controlled, and monitored because of the actions of a few.

PSROs will not:

- Be held accountable for the continuing escalation of Medicare and Medicaid expenditures because there is no direct relationship between hospital utilization and hospital reimbursement under these two programs.

- Develop a "cookbook" for medical care.

The PSRO program has withstood potent resistance during its short life. Its continued vitality will depend, in large measure, on increasing levels of physician awareness and support. Such physician involvement is a precondition for meaningful MD input in the formulation of health care policy. If physicians pursued such involvement appropriately, they may reap significant dividends for their profession, their patients, and the facilities in which they practice.

Future columns will describe some of the current activities of MDs active in Michigan PSROs.

Doctor Fall is MSMS representative to and president of the Professional Standards Review Council.

Appeals Court decision reverses former minors' contraceptive position

By A. Stewart Kerr, MSMS legal counsel

The Sixth Circuit Court of Appeals on Feb. 26 reversed a Michigan Federal District Court Judge's decision that parents have a right to notification of their children's use of contraceptives. The decision may have far-reaching ramifications regarding the right to privacy in conjunction with minors' rights.

In *Doe v. Irwin*, the Court of Appeals reviewed the procedures of Tri-County Family Planning Center, operated in Lansing by the Ingham County Health Department.

Minors were permitted to enter the Center and use its services with or without their parents' consent. Weekly "rap sessions" were conducted by the center and no minors were permitted to receive contraceptives until attendance at least at one rap session.

Female patients under the age of 18 were permitted to receive birth control pills without the notice or consent of their parents. Some female patients received intra-uterine devices, but to obtain them, these patients needed the consent of their parents.

Female patients were usually given a three-month supply of birth control pills, which are normally prescription drugs. The center did not ask the minors whether they had parental consent before the contraceptives were given to them. The center did not notify the minors' parents that their children had attended a rap session and/or received contraceptives.

A class action was filed, the plaintiffs consisting of "all parents residing in the county of Ingham who have children between the onset of puberty and the age of majority under their parental care, custody and control" who opposed the practices of the center.

The Western District Court ultimately held that the center was to cease its operation of distributing

contraceptives and contraceptive devices to minors in the absence of notice to the parents. The parents of the minors must be allowed a reasonable opportunity to consult with their children as to whether the child may obtain contraceptives or contraceptive devices, the lower court ruled.

In its subsequent decision, the Court of Appeals indicated that although the state has somewhat broader authority to regulate the conduct of children than that of adults, minors do possess a constitutionally protected right of privacy.

The court noted that parental concern for the nurture and the upbringing of their children is critical, but also pointed out that the Supreme Court had not squarely decided the issue of whether a parent must have notice of and give consent to the child's use of contraceptives. Thus, the Court of Appeals did not consider itself bound by any precedent.

The Court of Appeals did not choose to weigh the interests of the parents against the interests of the children. Instead, it decided that there was no violation of the parents' rights. The court stated that the state may choose to impose a limitation on the minors' right but not yet has chosen to do so.

The court also noted that the center did not prohibit the parents from participating in the decisions of their minor children on issues regarding sexuality and birth control. The court saw no hindrance of the parents' ability to exercise their traditional care, custody and control over their children. Although the Center had no requirement that a parent consent to or be notified of their children's actions, there was no affirmative prevention of their participation with their children's decisions regarding sexual activity and birth control.

The Court of Appeals decision

has broad effects. It did not balance the rights of minors against the rights of parents but rather held that there was no violation of the parents' rights. This suggests that there is no requirement of parental notice and/or consent in any health care situation where the minor's participation is voluntary, where adequate information regarding the consequences of accepting medical care is disbursed along with the care and where no attempt is made to exclude parents from participation.

FTC's goals

A year ago FTC Commissioner Michael Pertschuk listed in a speech what the FTC proposes to examine in its "health care antitrust program:"

- Alleged professional association restraints on advertising;
- Use of relative value scales to stabilize fees;
- Professional associations allegedly condemning acceptance of non-fee-for-service employment by their members;
- Preferential payments to physicians by medical laboratories to obtain business;
- Alleged boycotts of cost-containment programs set up by insurance plans;
- Prospects for competition under national health insurance;
- Obstacles faced by health maintenance organizations;
- Limitations on the scope of practice of allied health practitioners;
- Potential cost savings through the use of generic drugs;
- Problems in the nursing home field; and
- Physician participation in control of open panel medical service plans, like Blue Cross Blue Shield.

Occupational diseases must be reported

Effective with May the state now requires reporting of occupational diseases, in accordance with recent law.

The state's Public Health Code imposes upon the state's employers and medical community new responsibilities related to occupational diseases. The Michigan Department of Public Health Division of Occupational Health, aided by an eight-member advisory committee, laid the groundwork to carry out the code's mandate.

The Code requires physicians, hospitals, clinics, and employers to report known or suspected cases of occupational disease to the MDPH within 10 days after discovery.

The purpose of the requirement is to collect information on occupational diseases that is truly representative of diseases of the workplace, as

well as information on the kinds of employment leading to those diseases.

Conditions covered include skin diseases; dust diseases of the lungs, such as pneumoconioses; respiratory conditions due to toxic agents; poisoning (systemic effects of toxic materials); disorders due to physical agents, like heat, cold, or radiation; disorders associated with repeated trauma, such as noise-induced hearing loss; and other occupational illnesses.

Physicians, hospitals, clinics, and employers presently are receiving a reporting form in the mail. The form was developed by MDPH personnel with the assistance of advisory committee members representing medicine, industry, and labor. It is as simple and brief as possible, consistent with its need to generate the

necessary information.

The Health Department does not want to receive multiple reports on the same individual. Employers are to return the completed form only when employees are not referred to a physician, hospital, or clinic.

The form must be completed in all cases of suspected or actual occupational diseases or health conditions.

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Disciplinary actions, Michigan Board of Medicine

The following actions of the Michigan Board of Medicine were taken following investigation and appropriate administrative action, are printed from official memoranda to MSMS and are not editorialized:

February 7, 1980 to date (March 3, 1980)

Name & Address	Date & Action Taken	Violation
Richard W. Sundling, MD 4055 Red Barn Circle Chelsea, MI 48118 License #024848	2-6-80 License Revoked effective 9-6-79 from period of Summary Suspension	Personal disqualifications, consisting of any of the fol- lowing: Substance abuse as defined in Section 6107 Mental or physical inability reasonably related to and adversely affecting the li- censee's ability to practice in a safe and competent manner. Prohibited acts, consisting of any of the following: Obtaining, possessing or attempting to obtain or pos-

(continued on page 334)

Detroit-area Tel-Med® leads nation

By Mert Scholten, chief,
MSMS Communications

Michigan residents may be asking more questions about their health and well-being than just about anybody in the country!

That's a conclusion drawn from the just-released annual report of TEL-MED® Inc., the nationwide health information system experimentally begun eight years ago by the San Bernadino County Medical Society.

According to the report, Detroit's Tel-Med system draws an average of 25,500 calls per month and leads the nation in total calls, having drawn over 1,000,000 to date.

Collectively, the Michigan systems (including Detroit's) record over 56,000 calls per week. Michigan now has 13 Tel-Med systems in operation.

(continued on page 334)

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TEL-MED/continued

including the new Traverse City operation which has had no opportunity yet to compile any statistics.

This may free the doctor to spend more time discussing patients' deeper concerns.

There are now 335 tapes available from the Tel-Med tape library, which originally had only 50 tapes. The company estimates that approximately 142,000,000 Americans are being served by Tel-Med in 43 of the 50 states. An average of one million people call Tel-Med each month nationwide.

Michigan programs and their average number of calls per month include:

Ann Arbor	423
Battle Creek	Not Available
Flint	10,000
Grand Rapids	1,300
Hart	1,900
Jackson	2,000
Kalamazoo	4,200
Lansing	1,600
Muskegon	3,042
Pontiac	2,600
Saginaw	3,500
Traverse City	New Program

Funding for programs comes from many sources. In some cases the program is supported by the county medical society, in others by a hospital or by Blue Cross Blue Shield of Michigan. And in many instances the sponsorship is underwritten by multiple sources.

Proponents of the system point out that the presence of a Tel-Med system provides a true public service to citizens who are eager to learn about their health and practices necessary to maintain it. Very few areas of the state are without access to the service as a local or toll-free phone call.

While tapes discussing sexual topics and venereal diseases continue to lead the "most requested" lists for most operations, virtually all tapes are asked for at some time or another.

Most communities periodically publish current tape lists and the phone number of the system either in newspapers or publicly distributed folders in their efforts to keep citizens aware of the service. Many radio and television stations also carry public service spots advertising the service.

DISCIPLINARY ACTIONS/continued

Name & Address	Date & Action Taken	Violation
Harold Richard Kostoff, MD 1025 Huron Ave. Port Huron, MI 48060 License #022451	4-5-80 Suspension from 10-3-79 to 10-3-80	Being guilty of immoral conduct. Any conduct, practice, or condition which impairs or may impair, the ability to safely & skillfully practice the health profession. Personal disqualifications, consisting of any of the following: Mental or physical inability reasonably related to & adversely affecting the licensee's ability to practice in a safe and competent manner. A violation of general duty consisting of negligence or failure to exercise due care, including negligent delegation to or supervision of employees or other individuals, whether or not injury results, or any conduct, practice, or condition which impairs, or may impair the ability to safely and skillfully practice the health profession. Incompetence Substance abuse as defined in Section 6107. Prohibited acts, consisting of any of the following: Obtaining, possessing, or attempting to obtain or possess a controlled substance as defined in Section 7104 without lawful authority or selling, prescribing, giving away, or administering drugs for other than lawful diagnostic or therapeutic purposes.
Pedro P. Berdayes, MD 18145 Mack Avenue Detroit, MI 48224 License #027464	4-2-80 License Revoked	A departure from, or failure to conform to, minimal standards of acceptable and prevailing medical practice, whether or not actual injury to a patient is established.
Robert C. Henry, MD 3865 Waldenwood Drive Ann Arbor, MI 48105 License #019731	4-2-80 Letter of Reprimand	

By Dennis Paradis, Director
MSMS Physician/HSA Support Center



Rules differentiate surgical outpatient facilities from private practice offices

In April, the MSMS House of Delegates resolved to intensify efforts to prevent extension of certificate of need (CON) requirements to physicians' private offices, by calling, if necessary, on new Michigan Department of Public Health rules differentiating free-standing, outpatient surgical clinics from private physicians' offices.

The following item elaborates on those MDPH rules, for MSMS members' clarification.

The Public Health Code (PA 368, 1978 as amended), Section 20115(2) mandates the Department of Public Health to promulgate rules differentiating a freestanding surgical outpatient facility from a private office of a practicing physician, dentist, podiatrist or other private office. The purpose of rules is to differentiate between freestanding surgical outpatient facilities which require licensure and fall under the state certificate of need legislation, and private practice offices which are exempt from licensure and certificate of need. The rules now read:

R325.6001. Freestanding surgical outpatient facilities; characteristics.

Rule 1. Characteristics of a freestanding surgical outpatient facility include, but are not limited to, the following:

(a) Patient encounters with a physician, dentist, podiatrist, or other provider are primarily for the purpose of performing surgical procedures or related diagnosis, consultation, observation, and postoperative care.

(b) The owner or operator makes the facility available to other physicians, dentists, podiatrists, or providers who comprise its professional staff.

R325.6002. Private practice offices; characteristics.

Rule 2. Characteristics of a private practice office of a physician, dentist, podiatrist, or other provider, include, but are not limited to, the following:

(a) Patients are limited to those of the individual licensed professional maintaining and operating the office or the combined patients of individually licensed professionals practicing together in a legally constituted professional corporation, association, or partnership, and sharing office space.

(b) The office is maintained and operated by the licensed professional in accord with usual practice patterns according to the type of practice. Patient encounters in the office are for the purpose of diagnosis and treatment and are not limited primarily to the performance of surgical procedures and related care.

MSMS Presidential Citations to physician health planners

Since the passage of the National Health Planning and Resources Development Act of 1974, a number of physicians have contributed many hours of their time to work with health systems agencies and the Statewide Health Coordinating Council. These physicians have been a guiding force in the health planning process and have earned the gratitude of their fellow physicians.

During the 1980 House of Delegates meeting, 1979-80 MSMS President Ernest P. Griffin, Jr., MD, awarded citations to 11 physicians who have served five or more years in the health planning arena. Presidential Citations were awarded to William C. Bock, MD, St. Joseph; Zane A. Brashares, MD, Brooklyn; Stuart L. Cohn, MD, Alpena; James D. Fryfogle, MD, Southfield; D. Bonta Hiscoe, MD, East Lansing; William O. Mays, MD, Bloomfield Hills; Joseph R. Montante, MD, Orchard Lake; Richard J. Potter, MD, Negaunee; Winston B. Prothro, MD, Haslett; James F. Tobin, MD, Ishpeming, and Ian Wilson, MD, Petoskey.



"First, the good news - Your glove compartment and sun visor are in excellent condition."



MSMS Auxiliary members spoke personally with their legislators at their recent annual Legislative Day at Kellogg Center, Michigan State University. Their legislators, such as Sen. Gary G. Corbin, Clio, above, joined them for lunch. With him are Carol Batdorf, center, and Mary Turcke, Genesee County.

1980 MSMS/A Legislative Day in pictures

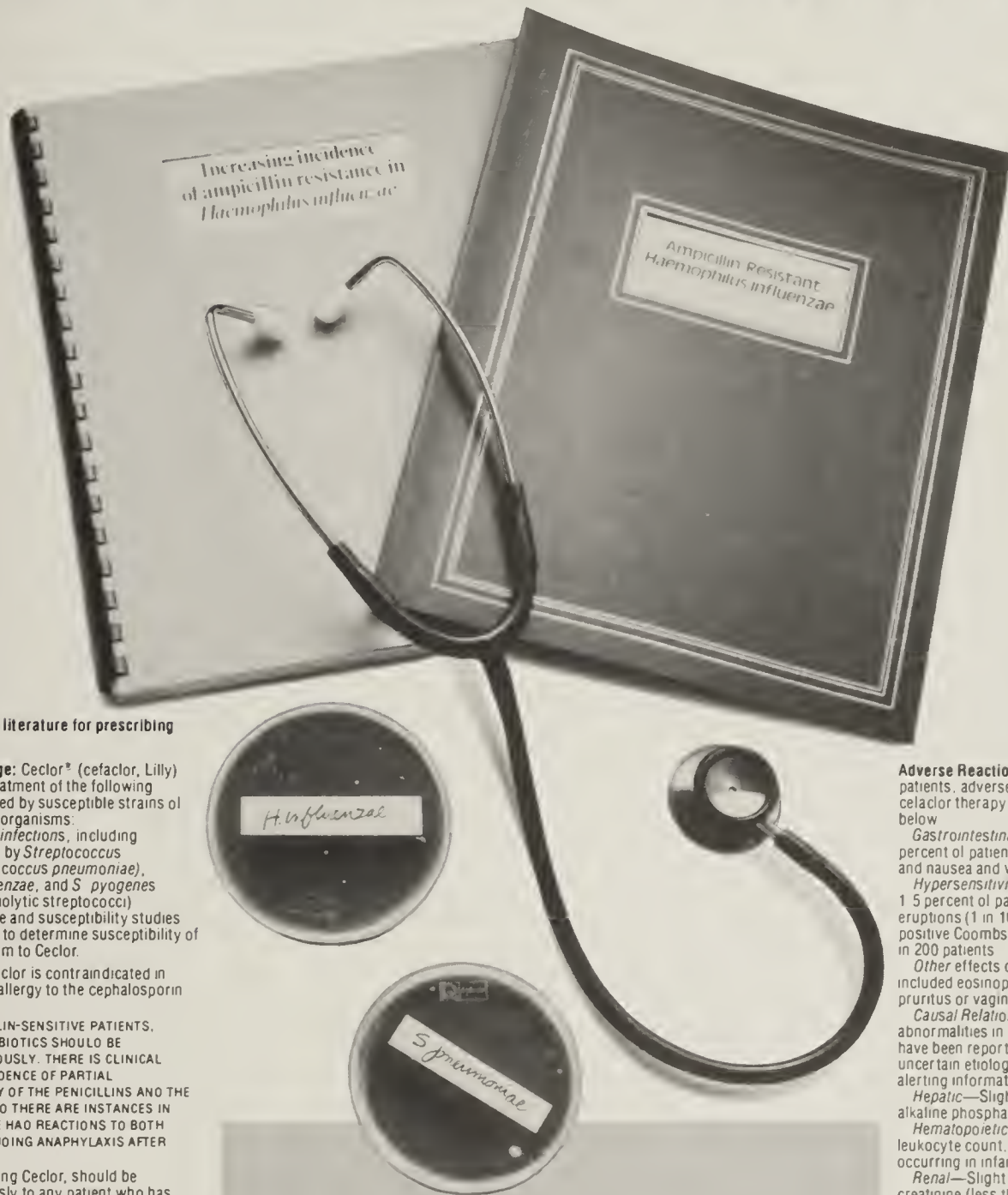


Barbara Wild, Ann Arbor, left, was Legislative Day chairman, and scheduled the luncheon speech by Sen. Edward Pierce, MD, center. With them is MSMS/A 1979-80 president Mildred Carron, Ann Arbor.



Auxiliary members heard talks on federal legislation (by Wayne Bradley, director, AMA Division of National Legislation; on state legislation (by MSMS Government Relations Department Manager Bruce Ambrose) and by then MSMS President Ernest P. Griffin, Jr., MD.

An added complication... in the treatment of bacterial bronchitis*



Brief Summary. Consult the package literature for prescribing information.

Indications and Usage: Ceclor® (cefactor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms:

Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae* (*Diplococcus pneumoniae*), *Haemophilus influenzae*, and *S. pyogenes* (group A beta-hemolytic streptococci)

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Ceclor.

Contraindication: Ceclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS, AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS TO BOTH DRUG CLASSES (INCLUDING ANAPHYLAXIS AFTER PARENTERAL USE).

Antibiotics, including Ceclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

Precautions: If an allergic reaction to cefactor occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids

Prolonged use of cefactor may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs test may be due to the drug.

Ceclor should be administered with caution in the presence of markedly impaired renal function. Under such a condition, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

Usage in Pregnancy—Although no teratogenic or antifertility effects were seen in reproduction studies in mice and rats receiving up to 12 times the maximum human dose or in ferrets given three times the maximum human dose, the safety of this drug for use in human pregnancy has not been established. The benefits of the drug in pregnant women should be weighed against a possible risk to the fetus.

Usage in Infancy—Safety of this product for use in infants less than one month of age has not been established.

Some ampicillin-resistant strains of *Haemophilus influenzae*—a recognized complication of bacterial bronchitis*—are sensitive to treatment with Ceclor.¹⁻⁶

In clinical trials, patients with bacterial bronchitis due to susceptible strains of *Streptococcus pneumoniae*, *H. influenzae*, *S. pyogenes* (group A beta-hemolytic streptococci), or multiple organisms achieved a satisfactory clinical response with Ceclor.⁷

Ceclor®

cefactor

Pulvules®, 250 and 500 mg

Adverse Reactions: In clinical studies in 1493 patients, adverse effects considered related to cefactor therapy were uncommon and are listed below.

Gastrointestinal symptoms occurred in about 2.5 percent of patients and included diarrhea (1 in 70) and nausea and vomiting (1 in 90).

Hypersensitivity reactions were reported in about 1.5 percent of patients and included morbilliform eruptions (1 in 100), Pruritus, urticaria, and positive Coombs tests each occurred in less than 1 in 200 patients.

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

Causal Relationship Uncertain—Transitory abnormalities in clinical laboratory tests results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician.

Hepatic—Slight elevations in SGOT, SGPT, or alkaline phosphatase values (1 in 40).

Hematopoietic—Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40).

Renal—Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200).

[070379B]

*Many authorities attribute acute infectious exacerbation of chronic bronchitis to either *S. pneumoniae* or *H. influenzae*.

Note: Ceclor® (cefactor) is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

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8. Principles and Practice of Infectious Diseases (edited by G. L. Mandell, R. G. Douglas, Jr., and J. E. Bennett), p. 487. New York: John Wiley & Sons, 1979.



Additional information available to the profession on request from Eli Lilly and Company, Indianapolis, Indiana 46285. Eli Lilly Industries, Inc., Carolina, Puerto Rico 00630.

000482

U-M physicians seeking patients for number of research studies

Experimental therapy for systemic lupus erythematosus

Your assistance is requested in identifying patients with systemic lupus erythematosus (SLE) who might be candidates for a double-blind study designed to investigate the efficacy of Frentizole therapy in treating SLE. Frentizole is an immunoregulatory drug which effectively suppressed clinical and laboratory manifestations of SLE in a preliminary open-label study.

The patients in the study will receive their medical care in the Clinical Research Unit and in the Outpatient Clinic at the Upjohn Center at the University of Michigan. Protocol medical care and laboratory tests will be free of charge.

The 6-12 month protocol allows variation in prednisone dose (up or down depending on the patient's needs) once the patient has entered the trial.

Ideal patients for this protocol are 1) those who experience a flare of SLE as the prednisone dose is tapered; 2) patients who have active disease in whom you would consider increasing the dose of prednisone; 3) new SLE patients whose disease is not suppressed by modest doses of prednisone; or 4) patients on prednisone whose active disease prompts consideration of immunosuppressive cytotoxic drug therapy.

Please contact Donald R. Kay, MD (313-764-9121) or Sara E. Walker, MD (313-764-1203) at the University of Michigan Medical Center, 1405 E. Ann St., Ann Arbor, Michigan 48109.

Studies in hormonal control of nutrient metabolism

The research project has the following objectives: 1) to study the mechanisms of regulation of plasma levels of pancreatic polypeptide in health and disease; 2) to study on a long-term basis the natural history of diabetes mellitus; 3) to characterize the hormone secretory profiles of pancreatic islet-cell tumors; 4) to define the causes of hormonal abnormalities in uncontrolled diabetes mellitus; 5) to define the factors which control gluconeogenesis during fasting; and, 6) to define the diurnal patterns of plasma levels of pancreatic hormones and growth hormone in health and disease. The following categories of patients are needed to carry out these studies: 1) patients with

newly diagnosed, uncontrolled, untreated diabetes mellitus; 2) patients with maturity-onset type diabetes mellitus which occurs in young age in families with strong family history of diabetes mellitus; 3) patients suspected to have pancreatic islet-cell tumors, such as insulinoma, glucagonoma, or multiple endocrine neoplasia, type I; and, 4) patients with active acromegaly.

Referrals on such patients should be made to Stefan S. Fajans, M.D.; John C. Floyd, Jr., M.D.; Ralph F. Knopf, M.D.; Sumer Pek, M.D. and Arthur Vinik, C7009 University of Michigan Hospital, Ann Arbor, Michigan 48109, (313) 764-4164.

Clinical studies on pheochromocytoma and thyroid cancer

We are searching for patients who will aid in the investigation of pathogenesis of familial pheochromocytoma and medullary carcinoma of the thyroid gland. The studies are conducted at the University of Michigan Medical Center.

Eligible patients are those with pheochromocytoma, suspected pheochromocytoma or medullary carcinoma of the thyroid. Although a familial nature to these diseases is of special interest, the patients need not be from an affected family. All patients will undergo a thorough clinical evaluation in the Clinical Research Center. Tests will be aimed at uncovering and defining tumors of the adrenal medulla and thyroid gland. Costs of hospitalization and tests are borne by the National Institutes of Health. However, patients must pay for their travel to and from the Center.

Physicians who desire further details of the investigation should contact: James C. Sisson, M.D., Nuclear Medicine Unit, University of Michigan Medical Center, Ann Arbor, Michigan 48109, (313) 763-4403.

Experimental Therapy for Skin Ulcers

We seek patients with indolent skin ulcers on the lower half of the lower extremity which have been resistant to therapy by the usual modalities of bed rest and local care. The ideal patients are those with multiple ulcers so that one or more can be observed as controls for those ulcers subjected to special management. Patients with indolent ulcers related either to rheumatoid arthritis, systemic lupus, atherosclerosis or to sickle cell disease are equally appro-

priate (at least initially). Patients are apprised ahead of time as to the experimental nature of this form of treatment and have to be judged capable of following the inpatient protocol.

The specific aim of this project is to ascertain whether or not Connective Tissue Activating Peptide-III (CTAP-III) will promote more rapid wound closure by stimulating the growth of granulation tissue in indolent skin ulcers. CTAP-III is a cationic protein isolated from outdated human platelets obtained from the blood bank.

Patients will be hospitalized on the Clinical Research Center in the University Hospital in Ann Arbor. They are maintained at bed rest or modified bed rest with bathroom privileges, depending on the severity of their disease. The nursing staff provides a careful, consistent level of care to the patient's multiple indolent ulcers under very close observation by the investigators.

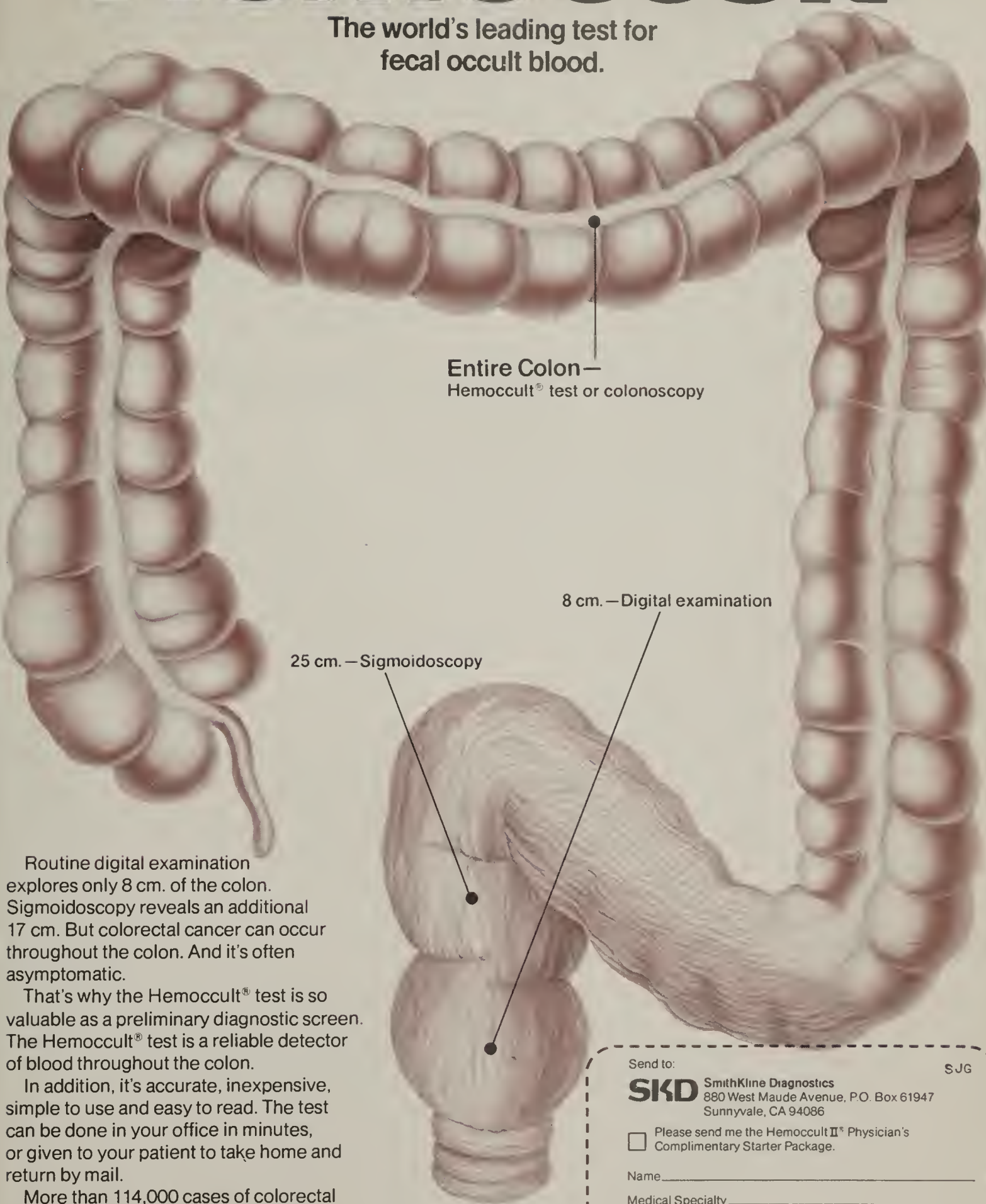
For further information concerning admission of patients to this study please contact: C. William Castor, MD, at 313/764-4422.

Experimental Therapy for Acute Lymphoblastic Leukemia or Lymphocytic Lymphoma

Patients with end-stage refractory acute lymphoblastic leukemia or lymphocytic lymphoma with marrow involvement are eligible for a study of the chemotherapeutic effects of 2'-deoxycoformycin, a new and potent antilymphocytic agent. Patients will be hospitalized in the Clinical Research Center at the University Hospital in Ann Arbor for the duration of treatment. For further information, please contact Beverly S. Mitchell, MD, Simpson Memorial Institute, The University of Michigan, Ann Arbor, 48109. Telephone: 313/764-8100.

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DIRECTIONS FOR USE — ADULTS: Before breakfast and after the evening meal, one to two rounded teaspoonfuls of Perdiem™ granules should be placed in the mouth and swallowed with a full glass of warm or cold beverage. Perdiem™ granules should not be chewed. After Perdiem™ takes effect (usually after 24 hours, but possibly not before 36-48 hours), reduce the morning and evening doses to one rounded teaspoonful. Subsequent doses should be adjusted after adequate laxation is obtained.

IN OBSTINATE CASES: Perdiem™ may be taken more frequently, up to two rounded teaspoonfuls every six hours.

FOR PATIENTS HABITUATED TO STRONG PURGATIVES: Two rounded teaspoonfuls of Perdiem™ in the morning and evening may be required along with half the usual dose of the purgative being used. The purgative should be discontinued as soon as possible and the dosage of Perdiem™ granules reduced when and if bowel tone shows lessened laxative dependence.

FOR COLOSTOMY PATIENTS: To ensure formed stools, give one to two rounded teaspoonfuls of Perdiem™ in the evening with warm liquid.

DURING PREGNANCY: Give one to two rounded teaspoonfuls each evening.

FOR CLINICAL REGULATION: For patients confined to bed, for those of inactive habits, and in the presence of cardiovascular disease where straining must be avoided, one rounded teaspoonful of Perdiem™ taken once or twice daily will provide regular bowel habits. Take with a full glass of water or beverage.

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NEWS

By Bonnie Groff, MSMS staff

State Senator **Edward C. Pierce, MD** (D-18th District), is recipient of special honors from the Michigan Association of Osteopathic Physicians and Surgeons. At the group's annual banquet at the Hyatt Regency Dearborn, Doctor Pierce was cited for outstanding leadership and humanitarian service to the improvement of health care for the citizens of Michigan. . . . New Director of Education for the American College of Obstetricians and Gynecologists is **Harrison C. Visscher, MD**. . . **Anna H. Broecker, MD**, is new president of the Kent Medical Foundation. Doctor Broecker, a past member of the board of directors and secretary-treasurer of the Kent County Medical Society, has been a trustee of the Foundation for five years. She succeeds **Albert E. Posthuma, MD** who completed his term as trustee. . . . **Muir Clapper, MD**, has been conferred a Mastership in the American College of Physicians. Of the ACP's nearly 50,000 total membership, only 159 individuals now hold the title of Master. The WSU School of Medicine professor is one of only three physicians presently living in Michigan to be so honored. . . . New president-elect of the Michigan Psychiatric Society and the Michigan District Branch of the American Psychiatric Association is **Emmanuel Tanay, MD**. . . . The Golden Tree of Life Award for distinguished service to the field of respiratory therapy has been awarded to **Thomas J. DeKornfeld, MD**, University of Michigan professor of anesthesiology, by the New York State Society for Respiratory Therapy, the largest respiratory therapy society in the United States. . . . **Richard B. Michelson, MD**, is leaving Michigan to take a position as medical director of Kansas City Blue Cross Blue Shield. He is a member of the MSMS Committee on CME Programming and was with the Commission on

Professional and Hospital Activities in Ann Arbor. . . . **Nelson M. Taylor, MD**, received the Wayne State University School of Medicine's Distinguished Alumni Service Award. The awards are presented each year to graduates of the school who, through their accomplishments in medicine and service to their communities, bring honor to themselves and to their alma mater. . . . **E. Gifford Upjohn, MD**, has retired from the Kellogg Foundation's Board of Trustees. In recognition of Doctor Upjohn's longtime service to the Foundation, the Board of Trustees passed a resolution stating: "We know and recognize Gifford Upjohn as a man of character and vision . . . We will continue to value his friendship and call on his knowledge and wise counsel." . . . **Ananias C. Diokno, MD**, professor of surgery at the University of Michigan Medical School, has been honored by the Philippine government as the outstanding Filipino in medical research overseas for 1979. Doctor Diokno was cited for his pioneering work in developing a test for disorders of the bladder and urinary control muscles and a technique for the repair of the ureter and urethra. . . . **Donald N. Sweeny, Jr., MD**, is chairman of the Amendments to Constitution and Bylaws Committee for the AMA's 1980 annual meeting in July. . . . **James Beaton, MD**, is president-elect of the American Fertility Society. . . . The *Traverse City Record-Eagle* recently published an editorial by **James W. Hall, MD**. The article describes the relationship of the environment of the Traverse City area to its economy. . . . **Leonard DeLooff, MD**, was honored at a surprise dinner party by over 70 volunteer ambulance corps workers from the eastern UP. To thank him for the training help he has given them, the workers presented Doctor DeLooff with a special plaque of appreciation

and a commemorative silver-plated Winchester rifle. . . . **William N. Hubbard, Jr., MD**, president of the Upjohn Company in Kalamazoo, is new trustee to the Kellogg Foundation's Board of Trustees. From 1959 to 1970, Doctor Hubbard was dean of the University of Michigan's Medical School. . . . The American Society for Clinical Pharmacology and Therapeutics has presented the Elliot distinguished service award to **Chris J. D. Zarafonitis, MD**, Ann Arbor.



Broecker



Clapper



DeKornfeld



Upjohn

CATEGORY I COURSES

Michigan Medicine each month carries a list of opportunities in Michigan for doctors of medicine to obtain Category I credit toward meeting the requirements of Michigan law. Sponsors of Category I programs and courses in Michigan are invited to submit information for the monthly calendar.

Each listing below, of programs that carry at least 3 hours of Category I credit, indicates a contact person, so the physician can obtain details. Physicians with questions about accredited programs may phone MSMS Headquarters, 517/337-1351.

The following have been accredited directly by the AMA or by MSMS CME Accrediting Committee. Physicians may wish to write to the hospitals and organizations that are accredited and ask to be placed on mailing lists for announcements about future programs.

Organizations:

American Association for Hand Surgery, Warren
American College of Emergency Physicians, Lansing
American College of Psychiatrists, Southfield
American Society of Colon and Rectal Surgeons, Detroit
American Society of Dermatopathology, Ann Arbor
Ann Arbor Psychiatric Association
Commission Professional and Hospital Activities, Ann Arbor
Michigan Academy of Family Physicians
Michigan Academy of Plastic Surgery
Michigan State Medical Society
Michigan State University College of Human Medicine, East Lansing
Michigan Chapter, American Academy of Pediatrics
Michigan Dermatological Society
Michigan Heart Association
Michigan Lung Association, Lansing
Michigan Ophthalmological Society
Michigan Psychoanalytic Society
Michigan Society of Anesthesiologists
Noah Worcester Dermatological Society, Detroit
Section of Gastroenterology, American Society for Gastroenterology, Detroit
University of Michigan Medical Center, Ann Arbor
University of Michigan School of Public Health
Wayne State University School of Medicine, Detroit

Hospitals:

Bay County Medical Education (Bay Medical Center, Bay Osteopathic Hospital, Bay City Samaritan Hospital)
William Beaumont Hospital, Royal Oak
Beyer Memorial Hospital, Ypsilanti
Blodgett Memorial Hospital, Grand Rapids
Bon Secours Hospital, Grosse Pointe
Burns Clinic Med. Center, PC/Northern Michigan Hospitals Inc., Petoskey
Butterworth Hospital, Grand Rapids
Central Michigan Community Hospital, Mt. Pleasant
Chippewa County War Memorial Hospital, Sault Ste. Marie

Community Health Center of Branch County, Coldwater
Community Hospital Association of Battle Creek
Cottage Hospital of Grosse Pointe
Detroit-Macomb Hospital Association
Dickinson County Memorial Hospital, Iron Mountain
Ferguson-Droste-Ferguson Hospital, Grand Rapids
Grace Hospital, Detroit
Gratiot Community Hospitals, Alma
Hawthorn Center, Northville
Henry Ford Hospital, Detroit
Heritage Hospital, Taylor
Holy Cross Hospital, Detroit
Hurley Medical Center, Flint
Ingham Medical Center, Lansing
Kalamazoo Regional Psychiatric Hospital
Lakeshore Continuing Medical Education, Inc. (Hackley Hospital and Mercy Hospital, Muskegon)
Leila Y. Post Montgomery Hospital, Battle Creek
Marquette General Hospital
McLaren General Hospital, Flint
Mecosta County General Hospital, Big Rapids
Mercy Hospital, Port Huron
Metropolitan Regional Psychiatric Hospital
Michigan Psychoanalytic Society, Southfield
Midland Hospital Center
Mt. Carmel Mercy Hospital & Med. Center, Detroit
Munson Medical Center, Traverse City
North Detroit General Hospital, Detroit
Northville Regional Psychiatric Hospital
Oakwood Hospital, Dearborn
Orthopedic Guild, Inc., St. Joseph
Pennock Hospital, Hastings
Pontiac General Hospital, Pontiac
Portage View Hospital, Hancock
Port Huron Hospital CME Committee
Providence Hospital, Saginaw
Saginaw Cooperative Hospitals, Inc., Saginaw
Southwestern Michigan Area Health Education Center (Bronson Hospital and Borgess Hospital), Kalamazoo
St. Francis Hospital, Escanaba
St. John Hospital, Detroit
St. Joseph Hospital, Flint
St. Joseph Mercy Hospital, Pontiac
St. Joseph Mercy Hospital, Ann Arbor
St. Lawrence Hospital, Lansing
St. Mary's Hospital, Grand Rapids
St. Mary Hospital, Livonia
Sinai Hospital of Detroit, Detroit
Southwest Detroit Hospital
Edward Sparrow Hospital, Lansing
Traverse City Regional Psychiatric Hospital, Traverse City
V.A. Hospital, Battle Creek
West Shore Consortium, CME, Ludington/Hart/Manistee
Ypsilanti Regional Psychiatric Hospital, Ypsilanti

Date: June 11, **First Annual Regional Medical Conference on Infectious Disease.** **Location:** Southwestern Community College, Dowagiac
Sponsor: Lee Memorial Hospital and Southwestern Michigan Area Health Education Center. **For:** All interested physicians and health personnel. **Cost:** Advance: \$35 physicians, \$20 allied health personnel; Walk-in: \$45 physicians, \$30 allied health personnel. **Contact:** Judith B. Willis, MD, PA-C, SMAHEC, 252 East Lovell, Kalamazoo, 49007, 616/383-6360. **Approved for:** 6 hours of Category I Credit.

Date: June 19-21, **31st Annual Keyport-Gaylord Trauma Symposium.** **Location:** Hidden Valley Club, Gaylord. **Sponsor:** Michigan Committee on Trauma, A.C.S. **Cost:** \$30. **Contact:** Theresa Sokol, Dept. of Surgery, Wayne State Univ., 540 E. Canfield, Detroit, 48201. **Approved for:** 12 hours of Category I Credit.

Date: June 22-27, **16th Annual Northern Michigan Summer Conference.** **Location:** Shanty Creek, Bellaire. **Sponsor:** U-M Office of Continuing Medical Education. **For:** All interested physicians. **Cost:** \$225. **Contact:** Towsley Center for CME, 313-764-2287. **Approved for:** 21½ hours of Category I Credit.

Date: July 11-14, **Internal Medicine Conference.** **Location:** Grand Hotel, Mackinac Island. **Sponsor:** U-M Office of Continuing Medical Education. **For:** All interested physicians. **Cost:** \$150. **Contact:** Towsley Center for CME, 313/764-2287. **Approved for:** 11 hours of Category I Credit.

Date: July 21-25, **American College of Physicians — MKSAP V Review Course.** **Location:** Education and Research Center, Henry Ford Hospital, Detroit. **Sponsor:** Henry Ford Hospital and American College of Physicians. **For:** All interested physicians. **Cost:** ACP members \$200, Residents and Research Fellows, \$200 Nonmembers, \$300; ACP Associates \$100. **Contact:** Medical Education, Henry Ford Hospital 2799 W. Grand Blvd., Detroit, 48202, 313/876-1464. **Approved for:** 30 hours of Category I Credit.

Date: July 24-25, **Coller Penberthy Thirlby Medical Conference.** **Location:** Park Place Motel, Traverse City. **Sponsor:** Munson Medical Center. **For:** All interested physicians. **Cost:** \$45. **Contact:** Norma Powers, Munson Medical Center, Traverse City, 49684. **Approved for:** 9 hours of Category I Credit.

Date: July 25, **Recent Advances in Pacemaker Technology.** **Location:** Towsley Center, Ann Arbor. **Sponsor:** U-M Office of Continuing Medical Education. **For:** All interested physicians. **Cost:** \$50. **Contact:** Towsley Center for CME 313/764-2287. **Approved for:** 6¼ hours of Category I Credit.

Date: July 25-27, **1980, EKG Interpretation and Arrhythmia Management.** **Location:** Grand Hotel, Mackinac Island. **Sponsor:** International Medical Education Corporation. **For:** All interested physicians. **Cost:** \$215.00. **Contact:** International Medical Education Corporation, Division of Postgraduate Education, Dept. 12, 64 Inverness Drive East, Englewood, CO 80112 (800) 525-8646 Toll Free or (313) 773-1144. **Approved for:** 15 hours of Category I Credit.

Date: July 26, **Symposia on Teaching Skills.** **Location:** Holiday Inn, Traverse City. **Sponsor:** American Academy of Family Physicians. **For:** All members of the AAFP. **Contact:** Michigan Academy of Family Physicians, 416 N. Homer Suite 107, Lansing. **Approved for:** 4 hours of Category I Credit.

Date: July 28-30, **Michigan Academy of Family Physicians 34th Annual Scientific Assembly.** **Location:** Holiday Inn, Traverse City. **Sponsor:** Michigan Academy of Family Physicians. **For:** Members of MAFP. **Contact:** Michigan Academy of Family Physicians, 416 N. Homer, Suite 107 Lansing 48912, 517/337-2065. **Approved for:** 15½ hours of Category I Credit.

Date: July 31-Aug. 3, Michigan Ophthalmological Society Twelfth Annual Summer Conference. **Location:** Grand Hotel, Mackinac Island. **Sponsor:** Michigan Ophthalmological Society. **For:** Ophthalmologists. **Cost:** \$75. **Contact:** Anya Miller, MSMS headquarters, 517-337-351. **Approved for:** 7 hours of Category I Credit.

Date: Aug. 22-25, 6th Annual Mackinac Island Conference. **Location:** Grand Hotel, Mackinac Island. **Sponsor:** U-M Office of Continuing Medical Education. **For:** All interested physicians. **Cost:** \$150. **Contact:** Towsley Center for CME, 313/764-2287. **Approved for:** 11 hours of Category I Credit.

Date: Aug. 23-24, Anatomy and Techniques of Regional Anesthesia. **Location:** Wayne State University School of Medicine, Scott Hall, Detroit. **Sponsor:** Wayne State University. **For:** All interested physicians. **Contact:** Wayne State University School of Medicine, Division of Continuing Medical Education, 9B-32 Health Care Institute, Detroit, 48201. **Approved for:** 12 hours of Category I Credit.

Date: Sept. 13, The Practical Application of Electron Microscopy to Surgical Pathology. **Location:** Munson Medical Center, Traverse City. **Sponsor:** Michigan Society of Pathologists. **For:** Pathologists. **Contact:** T. A. Reyman, MD, Department of Pathology, Mt. Carmel Mercy Hospital, Detroit, 48235. **Approved for:** 3 hours of Category I Credit.

Date: Sept. 24, Renal Problems for the Practicing Physician. **Location:** Kalamazoo Center, Kalamazoo. **Sponsor:** Michigan Nephrology Center. **Co-Sponsor:** Southwestern Michigan

Area Health Education Center. **For:** All primary care physicians. **Cost:** \$40. **Contact:** Charles L. Zeller, Jr., MD, Continuing Medical Education, 252 East Lovell, Room 364, Kalamazoo, 49007. **Approved for:** 7 hours of Category I Credit.

Date: Sept. 25-26, Nitrosoureas: Current Status and New Developments. **Location:** Hyatt Regency Dearborn. **Sponsor:** Wayne State University School of Medicine Department of Oncology, Harper-Grace Hospitals and the Comprehensive Cancer Center of Metropolitan Detroit and Bristol Laboratories. **For:** All interested physicians. **Contact:** David Moss, Symposium Coordinator, Bristol Laboratories, P.O. Box 657, Syracuse, NY 13201. **Approved for:** 12 hours of Category I Credit.

Date: Sept. 25-27, Electrophysiology of Cardiac Arrhythmias and Conduction Defects. **Location:** Detroit Plaza Hotel. **Sponsor:** Michigan Heart Association and Council on Clinical Cardiology of the American Heart Association. **For:** All interested physicians. **Contact:** Eleanor D. Peterson, RN, Michigan Heart Association, P.O. Box LV 160, Southfield, 48076. 313/557-9500. **Approved for:** 16½ hours of Category I Credit.

Date: Oct. 2-5, Michigan Chapter, American College of Physicians Regional Meeting. **Location:** Sugar Loaf, Cedar. **Sponsor:** Michigan Chapter, American College of Physicians. **For:** Internists and family physicians. **Contact:** Boy Frame, MD, Henry Ford Hospital, 2799 W. Grand Blvd., Detroit, 48202. 313/876-2373. **Approved for:** 20 hours of Category I Credit.

Date: Oct. 3-5, Diagnostic Ultrasound. **Location:** Towsley Center, Ann Arbor. **Sponsor:** U-M Office of Continuing Medical Education. **For:** All

interested physicians. **Cost:** \$175. **Contact:** Towsley Center for CME, 313/764-2287. **Approved for:** 16 hours of Category I Credit.

Date: Oct. 15, Pediatrics Infections. **Location:** Hurley Medical Center, Merliss Brown Auditorium. **Sponsor:** Hurley Medical Center. **For:** All interested physicians. **Contact:** Richard D. Garlick, Hurley Medical Center, Sixth Ave. and Begole, Flint, 48502 313/766-0142. **Approved for:** 6 hours Category I Credit.

Date: Nov. 18-20, MSMS Annual Scientific Meeting. **Location:** Hyatt Regency Dearborn. **Sponsor:** Michigan State Medical Society. **For:** All interested physicians. **Contact:** Sherry Fent, MSMS, 517/337-1351. **Approved for:** 18 hours of Category I Credit.



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NEW MEMBERS



Members of the Michigan State Medical Society join in welcoming the following new members into a progressive state medical organization. MSMS is dedicated to promoting the science and art of medicine, the protection of the public health, and the betterment of the medical profession. Each new member is encouraged to join with other MSMS members at both the local and state levels in achieving these goals.

Douglass F. Adams, MD R
Univ. Hosp. Rad. B4145
Ann Arbor, 48109

Alicia E. Alimboyoguen, MD GP
2146 Bellechasse Dr.
Davison, 48423

Necla S. Aydar, MD
421 McNeal St.
Jackson, 49203

Evalt Ayerdi, MD
3752 Pine Tree Terrace
Portage, 49081

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2117 16th St.
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3535 W. 13 Mile Rd. #504
Royal Oak, 48072

Bruce L. Brown, MD
4126 Old Field Trail
Kalamazoo, 49008

L. E. Cachuela, MD
Oakdale Regional Ctr.
Lapeer, 48446

Wayne W. Charland, MD
Grand View Hosp. Box 708
Ironwood, 49938

Woon-Man Chung, MD
1215 E. Michigan
Lansing, 48909

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Munson Medical Ctr.
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Delois D. Daniels, MD
3800 Woodward #1100
Detroit, 48201

Francisco L. De Guia, MD
104 Fourth St.
Frankfort, 49635

Vijay K. Dixit, MD
1998 Dorchester #206
Troy, 48084

Nitin C. Dosi, MD
880 Woodward #14
Pontiac, 48053

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6767 W. Outer Dr.
Detroit, 48235

Walter O. Erxleben, MD
501 N. Maple
Ann Arbor, 48103

Imogene G. Fairchild, MD
18082 North Shore Estates
Spring Lake, 49456

Joseph J. Gadbaw, MD
6777 W. Maple
West Bloomfield, 48033

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Ok Kyun Kang, MD 28 Frost St. Flint, 48504	GS
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Dennis W. Konzen, MD 25 E. Centre St. ortage, 49071	FP
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ames W. Leete, MD 50 Osborn Blvd. ault Ste. Marie, 49783	FP
o Anne Levitan, MD 970 Telegraph Rd. #213 irmingham, 48010	PS/GS
orsey Ligon, MD 6 Sheldon Ave., SE #502 rand Rapids, 49503	OBG
Michael Lubetsky, MD 55 S. Livernois ochester, 48063	RHU/IM
ames D. McCullough, MD 340 Adare Rd. ann Arbor, 48104	A
Robert C. Medlar, MD 24 W. Franklin ackson, 49203	ORS
errence L. Meece, MD 007 Orchard Dr. Midland, 48640	FP



Following elections April 27, these MSMS leaders posed for the camera. From left are Wil E. Maldonado, MD, assistant secretary; Gerald H. Mandell, MD, vice speaker, MSMS House of Delegates; Thomas R. Berglund, MD, Council vice chairman; Louis R. Zako, MD, Council chairman; Dean P. Carron, MD, assistant treasurer and Council Finance Committee chairman; Robert J. Toteff, MD, Council Scientific and Educational Affairs Committee chairman, and Charles L. Oppy, MD, Council Legislative Policy Committee.

George B. Moser, MD 622 N. Woodward Birmingham, 48012	OBG	Nanda G. Salem, MD 3535 W. 13 Mile Rd. #707 Royal Oak, 48072	IM/NEP
J. R. Pandyan, MD 1124 Briarcliffe Dr. Flint, 48504	GS	John R. Sanborn, MD 16800 W. 12 Mile Rd. Southfield, 48076	OBG
Chong Hoon Park, MD 9964 Dorian Dr. Plymouth, 48170	IM/CD	Richard S. Schwartz, MD 5885 M-15 Clarkston, 48016	D
Chungsuk Kim Park, MD 620 Byron Rd. Howell, 48843	OBG	Bilugali M. Sundara, MD 101 W. John St. Bay City, 48706	PD/PHO
Sang H. Park, MD 4672 Hill St. Cass City, 48726	OBG	Doan Tran, MD 47 Austin St. Sandusky, 48471	GP
Jane C. S. Perrin, MD 3535 W. 13 Mile Rd. #703 Royal Oak, 48072	PM	Joaquin O. Uy, MD 2455 Traver Blvd. Ann Arbor, 48105	R/NM
Luis A. Pomodoro, MD 36331 Lyman Farmington Hills, 48018	P	Daniel M. Webster, MD 1213 W. Front St. Traverse City, 49684	FP
James E. Rasmussen, MD 1415 E. Ann St. C-2069 Ann Arbor, 48019	D	Arno W. Weiss, Jr., MD 16690 Colvin Rd. St. Charles, 48655	PS/OTO
Gary J. Roberts, MD Medical Park Iron Mountain, 48901	ORS	Jose A. Zuniga, MD 29270 Franklin Hills Southfield, 48034	N

DEATHS



Bernhard T. Alm, MD Petoskey

Bernhard T. Alm, MD, Petoskey, died Mar. 31 at the age of 72. Doctor Alm received his MD from Wayne State University School of Medicine in 1935. He was a former member of the medical staff of Fisher Body and former medical director for Gleaner Life Insurance Company in Detroit. Until his retirement 10 years ago, Doctor Alm was chief of staff at Lockwood-MacDonald Hospital in Petoskey.

Henry B. Hollis, MD Detroit

Henry B. Hollis, MD, Detroit, died Apr. 10. He was 75. A practicing physician in Detroit since 1942, Doctor Hollis was a lifetime member of the NAACP and the National Medical Association. He earned his MD from Meharry Medical College in Nashville.

Samuel B. Milton, MD Lincoln Park

Samuel B. Milton, MD, Lincoln Park, died Mar. 17 at the age of 76. Doctor Milton was founder and medical director of the Sidney A. Sumby Memorial Hospital, River Rouge. He received his MD from Northwestern University in 1928. In 1949, when voters named him county coronor, Doctor Milton became the first black man since 1892 to be elected to public office in Wayne County.

Henry Russell, MD Taylor

Henry Russell, MD, Taylor, died Mar. 13. He was 67. Doctor Russell graduated from Harvard Medical School in 1938. During his career, he served on the staffs of Oakwood, Outer Drive, Seaway, Wyandotte General, Heritage and Children's hospitals. He was also a board member of the Child Guidance Clinic.

Benjamin W. Stockwell, MD Grosse Pointe Farms

Benjamin W. Stockwell, MD, Grosse Pointe Farms, died Mar. 231 at the age of 72. A graduate of the University of Michigan Medical School, Doctor Stockwell served on the staff of Harper Hospital. He was a fellow of the American College of Surgeons and the American Board of Surgery.

Malcolm J. Tear, MD Troy

Malcolm J. Tear, MD, Troy, died Mar. 24. He was 71. A 1936 graduate of Wayne State University School of Medicine, he was a doctor in the U.S. Army Air Corps from 1942 to 1946. Doctor Tear maintained a private practice in Detroit and was on the staff of Detroit Memorial Hospital.

CLASSIFIED

The rate for each classified advertisement in *Michigan Medicine* is 15¢ per word, with a minimum charge of \$7.50. Copy for classified advertisements should be received not later than the first of the month preceding the month of publication.

Positions open

Physician Wanted for Jackson Med Center, Inc., a non-profit clinic. Position includes directing capable medical support staff, monitoring and providing patient care and planning for future expansion of present and future services provided. Ideal opportunity for aggressive physician interested in operating a "no risk" general practice. Internists and/or Family Practitioner preferable. Excellent salary (presently up to \$50,000) and fringe benefits. No investment required. Max. 40 hour work week. Resumes to: Jackson Med Center, Inc., 612 First Street, Jackson, MI 49203. Attention: E. Willoughby, MD.

Industrial Surgical Practice: In Cleveland suburb. Lucrative, well established. Associate two to four years and then buy. Please send C.V. to Box 21, Michigan State Medical Society, 120 W. Saginaw, East Lansing, MI 48823.

Physician Needed to cover days off for full time doctor. Skilled physical diagnosis and educative work required. No evenings or weekends. Ypsilanti, Michigan. 313-482-6790.

Physician With Michigan License and board-certified in a specialty to serve as Director of Medical Services in Upper Peninsula maximum security prison for males. Full-time position requires 40-hr/week in an ambulatory and inpatient facility, plus availability for on-call and emergency coverage 24 hours a day/7 days a week. Salary up to \$59,500, sufficient paid time-off for CME's, plus civil service employment benefits, commensurate with experience and qualification. Contact Marquette Branch Prison, Personnel Office, P.O. Box 779, Marquette, MI 49855.

OB-GYN: Board eligible or certified to join established mixed group including 2 ob-gyn spec. Ob practice directed toward family oriented childbirth concepts. Income and responsibility of existing Ob practice divided equally from first day of employment. Professional corp. with many fringe benefits. Excellent office and hospital facilities located in beautiful vacation area. Please send resume to: Robert J. Pranger, Bus. Adm., Medical Arts Group, P.C., 20 Cobb St., Cadillac, MI, 49601 or call (616) 775-6521.

Wanted — Full-time Staff Physician for 350-bed accredited hospital providing rehabilitation, psychiatric and chronic disease services. General practice or internal medicine training and experience beneficial. Successful candidate must have Michigan license. Excellent salary and fringe benefits. Submit qualifications to: Personnel Director, Saginaw Community Hospital, 3340 Hospital Road, Saginaw Michigan 48605.

Two Physicians Needed for Munising, Michigan. Rural community, gateway to Pictured Rocks National Park. Modern 40 bed hospital ICU, computerized nuclear scanner, office space and hospital located next to Lake Superior. New school system, excellent summer and winter sports. Great place to raise a family. Three physicians already in the area.

stable economic base. Contact Robert Hamilton, EVP, Munising Memorial Hospital, Sand Point Road, Munising, Michigan 49862.

Experienced General Surgeon needed to join two general internists, a gastroenterologist, three family practitioners and a pediatrician in a busy satellite of the Marshfield Clinic at Ladysmith, Wisconsin. Send Curriculum vitae to Sidney E. Johnson, MD, Medical Director, Marshfield Clinic, 1000 North Oak Ave., Marshfield, WI 54449, or call collect at (715) 387-5253.

Three Year Approved Psychiatric Residency Program now appointing for an immediate unexpected opening and for July, 1980. Small intensive psychiatric hospital, JCAH approved, affiliated with University of Iowa Medical College. Comprehensive program including two adult psychiatric units, adolescent unit, children's unit, alcohol & drug abuse unit, with innovative community liaison, and OPD. Eclectic approach. Situated in picturesque northeast Iowa near large cities with cultural advantages, but in rural setting. Ideal for family living. No financial sacrifice while learning. Top salary: first year \$24,669, second year \$25,854, third year \$27,123; liberal fringe benefits; some housing available. Opportunity to join staff upon completion of training. All applicants must have completed one year in an approved training program in internal medicine, family practice, or pediatrics or a flexible one year program, including four months in internal medicine. Write or call R. M. Akbar, MD, Acting Superintendent, or B. J. Dave, MD, Director of Education, Mental Health Institute, Independence, Iowa 50644. An Equal Opportunity Employer.

General Practitioner — to provide medical care in a small state facility for the mentally retarded, located in a rural setting in Michigan's beautiful Upper Peninsula. Current salary \$49,882 plus a liberal Civil Service fringe benefit package. Limited housing available at moderate cost. Write Steven A. Myers, MD, Chief of Clinical Affairs, Newberry Regional Mental Health Center, Newberry, Michigan 49868.

Family Practitioner — Tampa Bay Area — Florida. Federally qualified HMO is recruiting family practitioners for ambulatory care facilities in Clearwater, Florida. Competitive salary and comprehensive benefit program with opportunity to participate in academic program available. If team interaction and casual living appeal to you, send CV to: Prepaid Health Care, Inc., ATT: Jerry Williamson, MD, 1417 South Belcher Road, Clearwater, Florida 33516. (813)-535-3474.

Internist — Tampa Bay Area — Florida. Prepaid Health Care, Inc., a federally qualified HMO, is recruiting internists, BE or BC, for adult ambulatory care units in Clearwater and St. Petersburg. Excellent salary and benefit programs, with opportunity to participate in academic program available. Progressive, growing community. If interested in growing with us, send CV to Jerry Williamson, MD, Medical Director, 1417 South Belcher Road, Clearwater, Florida 33516. (813)-535-3474.

Positions With The State Of Michigan — Currently taking applications for positions expected to be available in the future. Primarily interested in board certified or board eligible internists with cardiology background. Office locations in Southfield, Lansing, and Traverse City. Also considering an office in Kalamazoo. Salary in 50's with approximately 40% fringe benefits. An equal opportunity employer. All enquiries treated confidentially. For further details please write: Disability Determination Service, P.O. Box 30011, Lansing, MI 48909, or call collect: Harry D. Nesmith, MD, Chief Medical Consultant (517) 373-7830. In Michigan, call toll free 1-800-292-2710.

General Surgeon — North Carolina. Needed for University owned hospital in small coastal town. This private practice opportunity is ideal for an experienced General Surgeon who would enjoy a relaxed, productive life style in a desirable climate on the coast. Send CV to MSMS, Box 20, 120 W Saginaw, East Lansing, MI 48823.

Internist with interest in cardiology, to join long established practice in rural community within 30 miles of large shopping areas. Active coronary care unit, excellent hospital and office facilities. Opportunity to become rapidly established in a busy practice with no investment. All Corporation fringes. Please call Area Code 517-846-6122 days or 846-4620 evenings, or write Malcolm K. Dolbee, MD, P.C., P.O. Box 609, Standish, Michigan 48658.

Miscellaneous

Medical Space For Lease. Roundtree Village Shopping Center — 2200-4400 sq. ft. available in Ypsilanti on Ellsworth Rd. at the corner of Hewitt. Just off I-94. Wayne Commons Shopping Center — 2200-4400 sq. ft. on Michigan Ave. near Wayne Rd. in city of Wayne. Well populated areas, ample parking, reasonable rent. Gordon Management Company, Inc., 313-647-7171.

For Sale: Established Gen/Family practice in Ypsilanti, Mich. Pleasant University community of 40,000-50,000 people. Office is fully equipped and consists of 2 exam rooms, lab, reception area, private physician's office and spare room, which may be used as a third exam room, billing/storage area. Building is well maintained and located across the street from 400 bed full service hospital. Occupancy can be immediate, we will assist in transition. For details contact: M. Ali, MD, 27 S. Prospect, Ypsilanti, MI, 48197, phone: 313-481-0015 or 313-697-9300.

Country Estate For Sale. By owner. 40 acres with additional acreage available on private lake. Spacious home. 50,000 sq. ft. living area. 5 bedrooms, 4 bathrooms, 3 fireplaces and guest quarters house. 4 years old. Located south central Michigan one hour from Ann Arbor, 45 minutes from Lansing and Kalamazoo. 2 hours from Detroit. Priced \$200,000. For information call: 517-629-5563 or 517-629-5090.

Luxury Chalet: perfect for 2-family or corporate ownership, accommodates 12-14. Fully furnished, 5 double bedrooms, 3 full baths, in leading northern Michigan all-season resort. 18 hole golf course, tennis, skiing, water sports, hunting, fishing, near excellent airport. Terms negotiable. Owner — (616) 587-9241.

Contemporary Medical Office — For October, 1980 occupancy on John R. between 11 and 12 mile roads Madison Heights. Tremendous growth area. Excellent opportunity for MD or DO medical physician. Up to 2,000 sq. ft. available. You can design your own office. Call Doctor S. J. Goldstein for additional information, 313/399-4905, 313/499-4370, 313/399-4691.

Lake Property in Caseville. 10 acres, 360 foot frontage, \$100,000. Evenings 313-769-1123.

Sanibel Island, Fla. Luxurious 2 bedroom, 2 bath condominiums on Gulf. Completely furnished including linens. Miles of uncrowded white sand beaches, fringed by lush tropical foliage, wild flowers, graceful sea oats and flowering trees. All amenities including pool, tennis, golfing, fishing, boating, sailing, bicycling and bird watching. Weekly, monthly discount. 313-645-5498.

Traverse City Michigan — Plenty of glass, magnificent modern 4 bedroom, 3 bathrooms, 2 fireplace home, living room, dining room, family room overlooking Lake Leelanau on Timberlee ski resort. Weekly or monthly, open

December thru April. Call Cindy Thompson 313-882-7060 or write 16840 E. Warren, Detroit, MI 48224.

Medical And Dental Office — 1000 sq. ft. suite available finish to suit. Tremendous growth location — 4147 Sixteen Mile Road, 2 blocks east of Ryan, Sterling Heights. Call B. Monast at 313/542-7100 or 313/979-7880.

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Mercywood Hospital 345

Michigan Physicians Mutual

Liability Company 311

Michigan State Medical Society

Annual Scientific Meeting ... 325

Roche 290, 291, 1BC, BC

Rorer, Inc. 340, 341, 342

Sandoz 321

Schering Corp. 308, 309

Smith, Kline, French 303, 339

Stratton Cheeseman 299

Upjohn 328, 329, 330

Wyeth Labs 315, 316



PRESIDENT'S PAGE

MDs may measure 80s success by affects on public opinion

John R. Ylvisaker, MD, MSMS President

Doctor Ylvisaker's comments here are taken from his inaugural speech delivered at the 1980 MSMS House of Delegates meeting April 25-27, at the Michigan Inn, Southfield.

The major measure of our leadership of the 80's will be the degree of success we achieve in molding public policy to permit the free marketplace to function in the field of health care.

The major issues we must address are:

- The role and direction of health planning and the manner of participation of the medical profession;
- The control of regulatory excesses, the the willingness of the medical profession to engage in the kind of fight which must be waged to reduce these excesses;
- The modification or replacement of the full service benefit form of financing of health care.

Major purposes

As we move to initiate our leadership of the 1980's with aggressive efforts to mold public policy, it also behooves us to examine carefully the compatibility of our purposes with such activities.

Our society's founders prescribed purposes which direct us internally to dedicate ourselves as a profession to excellence and currency of knowledge, application of that knowledge, ethical and moral behavior with patients and colleagues, compassion for our patients in their afflictions —

to professionalism, integrity, humanitarianism.

They do not direct us to the advancement of economic self-interest or advantage over others for status, privilege, or non-competitive territorial imperatives.

We are directed externally to societal obligations — to foster and maintain an environment in which the legitimate ideals of the medical profession can survive and flourish, in which patients can receive from trusted and trustworthy practitioners medical care which is appropriate to their needs both in quality and cost.

They direct us to responsible individual and collective civic, social and economic involvement to ensure that the public can receive proper care in a properly functioning system from providers who have the capacity and freedom to provide such care.

With only a few exceptions, our current activities are consistent with our purposes.

But, our members now evidence deep concern with the adverse effects of our changing environment — most particularly, the regulating and rule making of government and third parties negatively affecting basic freedoms and physician-patient relationships.

The recognized trend is the development of entrenched public policy which removes control of the health care system from health care professionals and transfers it to the hands of bureaucrats and well-intentioned but inexperienced and uninformed consumers. The insidious

result is a warping of standards of medical practice, and erosion of the mutual responsibilities of physicians and patients to each other.

Growing passivity

In this scenario of environmental trending, to me one of the worst effects is a growing passivity and acceptance of the tyranny of the status quo.

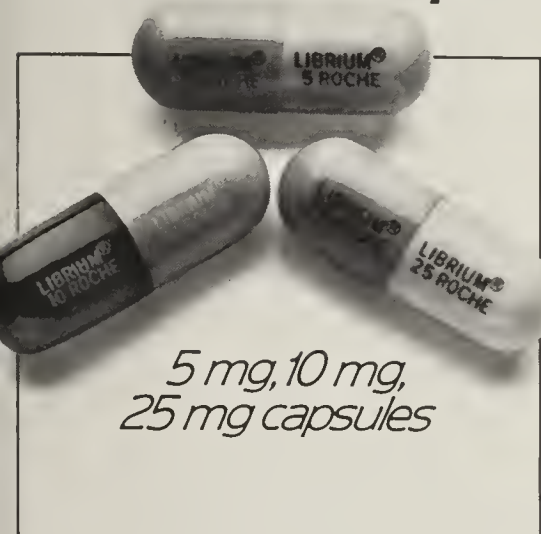
Our purposes as authored by our founders exhort us as medical leaders to meet the health needs of the people by working with other medical and with non-medical groups and individuals.

In our efforts to engage the major issues of the 1980's, I ask that you each join me with your thoughtfulness, advice, participation and support to further the single major purpose of our existence as a society.

That purpose is the sustaining and the advancement of the art and science of our profession for the humanitarian service of our patients.

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Before prescribing, please consult complete product information, a summary of which follows:

Indications: Relief of anxiety and tension occurring alone or accompanying various disease states. Efficacy beyond four months not established by systematic clinical studies. Periodic reassessment of therapy recommended.

Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Warn patients that mental and/or physical abilities required for tasks such as driving or operating machinery may be impaired, as may be mental alertness in children, and that concomitant use with alcohol or CNS depressants may have an additive effect. Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported.

Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and

acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

Usual Daily Dosage: Individualize for maximum beneficial effects. Oral—Adults: Mild and moderate anxiety and tension, 5 or 10 mg t.i.d. or q.i.d.; severe states, 20 or 25 mg t.i.d. or q.i.d. Geriatric patients: 5 mg b.i.d. to q.i.d. (See Precautions.)

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JUL 14 1980

Breaking News for Michigan Doctors

MICHIGAN MEDICINE

Vol. 79, No. 18
June 27, 1980

Brown-McNeely Fund insureds can join MPMLC

Michigan physicians who have been insured with the state's Brown-McNeely Fund are invited now to contact the Michigan Physicians Mutual Liability Company of East Lansing for coverage. The Brown-McNeely Fund no longer will be insuring physicians as of July 1. "We welcome applications from those Brown-McNeely insureds who elect to come with MPMLC," says MPMLC President Robert M. Leitch, MD, Battle Creek. "The Brown-McNeely Fund served a useful purpose during its early years following the malpractice insurance availability crisis. But it is no longer needed, as there is adequate insurance available through private insurance carriers." Interested physicians should contact MPMLC, 1305 Abbott Road, PO Box 1471, East Lansing, 48823, 517/351-1150.

THE MSU CENTER for Environmental Toxicology and the Michigan Agricultural Experiment Station plan a two-day workshop on PBB excretion June 30 and July 1 at MSU. Please call 517/353-7822.

In this issue . . .

is a complete list of the courses planned for the 1980 MSMS Annual Scientific Meeting Nov. 18-19-20 at the Hyatt Regency Dearborn. Registration and housing reservation forms will follow in later issues of the Medigram and in Michigan Medicine. For further information, please contact Sherry Fent at MSMS headquarters.

MEDIGRAM

FTC drops some witnesses; Testimony against MSMS ends early

The government has rested its case in the matter of the Federal Trade Commission vs. MSMS. The government's arguments and evidence followed expected directions with only a few unexpected positions, reports A. Stewart Kerr, MSMS legal counsel. "There was nothing too surprising," he says of the June 4-17 trial in Washington, DC. The FTC has charged MSMS with attempting to fix physicians' fees in Michigan in its dealings during recent years with Blue Cross Blue Shield of Michigan. "We're satisfied with the case to date," continues Mr. Kerr. "We have done better than we expected."

FTC testimony ended early when the government dropped a number of persons from its list of witnesses. "That shortened the case considerably," says William Sankbeil, of Kerr, Russell and Weber. "They now are relying largely on documents." MSMS briefs are due Aug. 22 and the MSMS case will be presented in Detroit courts beginning Sept. 22. "The judge agreed to come out here for the second portion of the trial," says Mr. Kerr. He estimates that change in venue will save MSMS at least \$15,000.

With Mr. Kerr in Washington for the opening phase of the trial were two other lawyers from his firm, Mr. Sankbeil and John Shoemaker; paralegal Mikal Manasco and secretary Linda Clegg.

MSMS members' opinion sought

How long a term do you think an MSMS officer should serve? Should MSMS Councilor districts be changed? What are the proper roles of MSMS officers? How should MSMS involve residents and interns? What could MSMS do to increase its membership?

The MSMS Task Force on MSMS Structure is seeking the answers to these and other similar questions. The Task Force, chaired by Donald N. Sweeny, Jr., MD, Detroit surgeon, invites any MSMS member to comment by writing the committee at MSMS headquarters, 120 W. Saginaw St., Box 950, East Lansing, 48823.

1980 MSMS Annual Scientific Meeting offers 54 courses at Hyatt Regency Dearborn

Half-day courses will be for 3 hours of Category I Credit. AAFP Prescribed Credit is pending. For more information, contact Sherry Fent at MSMS, 517/337-1351

November 18 Tuesday Morning (8:30 to Noon)

- "Care of the Elderly." Director: Roy G. Gerard, MD. Sponsored by Department of Family Practice, Michigan State University College of Human Medicine.
- "Current Concepts and Practical Therapeutic Approach to Non-Hodgkins Lymphoma." Director: Voravit Ratanatharathorn, MD. Sponsored by Department of Oncology, Wayne State University School of Medicine.
- "Denial in Alcoholism, Substance Abuse and Mental Health." Director: Russell F. Smith, MD, Medical Director, Brighton Hospital. Sponsored by MSMS Committee to Assist Impaired Physicians.
- "Management of Problems in Office Gynecology." Director: Bruce H. Drukker, MD, Henry Ford Hospital. Sponsored by Michigan Society of Obstetricians and Gynecologists.
- "Multi-Disciplinary Approach to Back Pain." Director: James I. Ausman, MD. Sponsored by Department of Neurological Surgery and Neurology, Henry Ford Hospital.
- "Occupational Medicine." Director: Lucius C. Tripp, MD, GM Proving Grounds, Milford. Sponsored by Michigan Occupational Medical Association.
- "Office Management of Common Pediatric Problems." Director: Lester Weiss, MD, Henry Ford Hospital. Sponsored by Michigan Chapter, American Academy of Pediatrics.
- "The Wet Ear — Diagnosis and Treatment for Primary Care Physicians." Director: Sean B. Peppard, MD. Sponsored by Department of Otolaryngology, Wayne State University School of Medicine.

Tuesday Afternoon (1:30 to 5:00)

- "Basic Life Support." Director: Craig E. Downs, DO, Lansing General Hospital. Sponsored by Michigan Chapter, American College of Emergency Physicians.
- "Brief Psychotherapy by the Primary Physician-Psychoanalyst Team." Director: Lawrence P. Tourkow, MD, Southfield. Sponsored by Michigan Psychoanalytic Society.
- "Chronic Abdominal Pain." Director: David S. Greenbaum, MD. Sponsored by Department of Medicine, Michigan State University College of Human Medicine.
- "Current Management of Renal Failure." Director: Nathan W. Levin, MD. Sponsored by Division of Nephrology, Henry Ford Hospital.
- "Diabetes — Current Management and New Horizons." Director: George L. Royer, Jr., MD, Kalamazoo. Sponsored by MSMS Section on Clinical Pharmacology.

- "Emergency Psychiatry: Theory & Practice." Director: Bonnie Fauman, MD, Henry Ford Hospital. Sponsored by Michigan Psychiatric Society.
- "Physicians as Expert Witnesses: Continuing Medical Care." Co-Directors: J. Douglas Peters, JD, Ann Arbor, and David B. Youel, MD, Kalamazoo. Sponsored by Michigan Medical Schools Council of Deans, Medical-Legal Project.
- "Tonsillectomy and Adenoidectomy — Current Status." Director: Ronald S. Bogdasarian, MD, Wayne County General Hospital. Sponsored by Michigan Otolaryngological Society.

November 19 Wednesday Morning (8:30 to Noon)

- "Advanced Cardiac Life Support." (A Provider Course to run all day Wednesday and Thursday.) Director: Craig E. Downs, DO, Lansing General Hospital. Sponsored by Michigan Chapter, American College of Emergency Physicians.
- "Clinical Toxicology in the Emergency Department." Director: Michael Clark, MD, Sparrow Hospital, Lansing. Sponsored by Michigan Chapter, American College of Emergency Physicians.
- "Colon Polyp — Cancer Sequence: A Rational Approach." Director: John P. Papp, MD, Grand Rapids. Sponsored by Michigan Society for Gastrointestinal Endoscopy.
- "Common Orthopaedic Problems." Director: Christopher L. Lee, MD, Wayne State University School of Medicine. Sponsored by Michigan Orthopaedic Society.
- "Dermatology for the Non-Dermatologist." Director: Margaret Douglass, MD, Henry Ford Hospital. Sponsored by Michigan Dermatological Society.
- "Effectiveness of Treating Hypertensive Patients: Newer Data." Director: Charles P. Lucas, MD. Sponsored by Department of Medicine, Wayne State University School of Medicine.
- "Genetic Issues in General Practice." Director: Saroj Kapur, MD. Sponsored by Department of Pediatrics and Human Development, Michigan State University College of Human Medicine.
- "Health Planning: Impact on the Physician and Patient Care." Director: Maurice S. Reizen, MD. Sponsored by Michigan Department of Public Health and MSMS Physician HSA/Support Center.
- "Psycho-Pharmacology: Anti-Depressants." Co-Directors: Linda Logsdon, MD, Southfield, and Kenneth Silk, MD, Ann Arbor. Sponsored by Michigan Psychiatric Society.

- “Skin Cancer — Including Malignant Melanoma.” Director: Errikos Constant, MD, Lansing. Sponsored by Michigan Academy of Plastic Surgeons.
- “Thoracic Trauma: Problems in Diagnosis, Early Management and Disposition.” Director: Dennis P. Horan, MD. Sponsored by Division of Trauma and Emergency Surgery, Henry Ford Hospital.

Wednesday Afternoon (1:30 to 5:00)

- “Alpha-Omega Session: Bronchial Asthma in Children and Adults.” Director: Cory E. Cookingham, MD, Flint. Sponsored by Michigan Allergy Society.
- “Current Approaches in Diagnosis and Management of Cancer of the Lung.” Director: Leif G. Suhrlund, MD. Sponsored by Department of Medicine, Michigan State University College of Human Medicine.
- “Current Concepts in the Management of Electrolyte Disorders.” Director: Richard L. Tannen, MD. Sponsored by Division of Nephrology, University of Michigan Medical School.
- “Diagnosis and Curative Management of Breast Cancer.” Director: Jerry C. Rosenberg, MD, Hutzel Hospital, Detroit. Sponsored by Wayne State University School of Medicine.
- “Diagnosis and Treatment of Colon and Rectal Disease.” Director: Robert E. McKnight, MD, Southfield. Sponsored by Michigan Society of Colon and Rectal Surgeons.
- “Everything You Always Wanted to Know About Local Anesthetics.” Director: Gaylord D. Alexander, MD, Sinai Hospital, Detroit. Sponsored by Michigan Society of Anesthesiologists.
- “Injuries to the Genito-Urinary Tract.” Director: Gerald F. Conway, MD, Royal Oak. Sponsored by Michigan Branch, American Urological Association.
- “Management of Difficult Soft Tissue Wounds.” Director: Errikos Constant, MD, Lansing. Sponsored by Michigan Academy of Plastic Surgeons.
- “Psycho-Pharmacology: Anti-Anxiety Drugs.” Co-Directors: Linda Logsdon, MD, Southfield, and Kenneth Silk, MD, Ann Arbor. Sponsored by Michigan Psychiatric Society.
- “Update on Cutaneous Mycology and Bacteriology — 1980.” Director: Margaret Douglass, MD, Henry Ford Hospital. Sponsored by Michigan Dermatological Society.

November 20

Thursday Morning (8:30 to Noon)

- “Chronic Head Pain.” Co-Directors: Eugene Rontal, MD, and Michael Rontal, MD, Southfield. Departments of Otorhinolaryngology, University of Michigan Medical School and Wayne State University School of Medicine.
- “Common Ophthalmic Problems.” Director: Frederick W. Bryant, MD, Royal Oak. Sponsored by Michigan Ophthalmological Society.
- “Elective Surgical Procedures in the Elderly.” Director: Angelos A. Kambouris, MD, Detroit. Sponsored by Department of Surgery, Henry Ford Hospital.

- “Management of Abortion — Current Aspects.” Director: Ruth S. Day, MD, St. Clair Shores. Sponsored by Michigan Psychiatric Society.
- “Non-Invasive Diagnosis of Peripheral Vascular Disease.” Director: Joseph P. Elliott, MD, Detroit. Sponsored by Second Surgical Division, Henry Ford Hospital.
- “Pre-Paid Health Plans: Alternate Medical Care?” Director: Jay Harness, MD, Ann Arbor. Sponsored by MSMS Advisory Committee to Bureau of Economics.
- “Workshop on Medical Ethics.” Director: Andrew D. Hunt, MD. Sponsored by Medical Humanities Program, Michigan State University College of Human Medicine.

Thursday Afternoon (1:30 to 5:00)

- “Arthrography, Arthroscopy and Radiologic Orthopaedic Correlation.” Director: Robert A. Songe, MD, Dearborn. Sponsored by Michigan Radiologic Society.
- “Cardiac Arrhythmias — Rational Use of Drugs.” Director: Thomas Killip, MD, Detroit. Sponsored by Department of Medicine, Henry Ford Hospital.
- “Care of the Injured Child.” Director: Arthur S. Besser, MD, Detroit. Sponsored by Division of Pediatric Surgery, Henry Ford Hospital.
- “CME Implementation in Community Hospitals.” Director: Floyd Pennington, PhD, Ann Arbor. Sponsored by Michigan Association for Medical Education.
- “Common Thoracic Problems.” Director: Raymond J. Barrett, MD, Southfield. Sponsored by Michigan Society of Thoracic Surgeons.
- “Current Concepts in Medical and Surgical Management of Ischemic Heart Disease.” Director: Agustin Arbulu, MD, Detroit. Sponsored by Michigan Chapter, American College of Chest Physicians.
- “Muscle Contractions, Fiber Types, and the Effect of Exercise Training.” Director: Charles J. Danek, MD, Traverse City. Sponsored by Michigan Academy of Physical Medicine and Rehabilitation.
- “Nuclear Medicine: Better Use of Available Tests.” Director: Daniel S. Marks, MD, Detroit. Sponsored by Michigan College of Nuclear Medicine Physicians.
- “Office Management of Common Infectious Problems.” Director: Erwin J. Haas, MD, Private Practitioner, Infectious Diseases, Grand Rapids.
- “Symposium on Pediatric Ophthalmology.” Director: Frederick W. Bryant, MD, Royal Oak. Sponsored by Michigan Ophthalmological Society.

PROSPECTS AREN'T GOOD for the 1980-81 Medicaid appropriations bill. Senate Fiscal Agency members say they are committed to passing all budget bills for the fiscal year, beginning Oct. 1. However, House members are not likely to get to the budgets since most are involved in August primary election battles, and may not wish to work on the further budget cuts which appear likely.

KENNETH J. RAY, MD, Trenton family physician, was installed June 9 as president of the Wayne County Medical Society. He succeeds C. Jackson France, MD, Detroit general surgeon. Chosen president-elect of the state's largest county medical society is Robert W. Black, MD Detroit internist. Elected WCMS secretary is Susan Adelman, MD, Southfield general surgeon, while Gerald H. Mandell, MD, Detroit pathologist, was elected to a five-year term on the WCMS seven-person board of trustees.

Senate focuses attention on cost amendments to HB 4555

With summer recess tentatively set to begin July 3, the State Senate expected to act the week of June 23 on the giant Blue Cross Blue Shield of Michigan reform bill--HB 4555. Most attention is focused on an amendment by Sen. Donald E. Bishop to remove a previous amendment for a one percent per year reduction in the formula for BCBSM payments to providers. That amendment, designed to deflate health care costs, was attached to the bill in the Senate Commerce Committee. The "deflater" amendment would make the voluntary effort cost goal almost certain to fail, which in turn would trigger intervention into health care benefits by the state insurance commissioner. The House of Representatives version of the BCBSM reform bill proposes a cost containment formula mutually agreed upon by provider groups and the Health Care Cost Containment Coalition. Physicians (both MD and DO), hospitals, pharmacists and dentists have been urged to contact their state senators to speak in favor of the Bishop amendment, in order to assure a Michigan cost containment program that will work.

Arbitration system 'unconstitutional'; insurance bureau awaiting orders

The Michigan medical arbitration system is proceeding as normal despite a May 22 ruling by Judge Victor Baum of the Wayne County Circuit Court that "the Michigan Medical Malpractice Act is unconstitutional, as applied." The basis of this opinion is that the medical malpractice arbitration statute "violates due process of law by depriving the malpractice claimant of the right to a hearing before a fair and impartial tribunal." Judge Baum held that the inclusion of a doctor or hospital administrator on a panel creates a built-in bias in favor of doctors and hospitals. Insurance Bureau is evaluating the opinion while awaiting Judge Baum's order of directed action.

Michigan State Medical Society
120 West Saginaw Street
East Lansing, Michigan 48823

MICHIGAN MEDICINE

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Editor: Judith Marr

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MICHIGAN MEDICINE

Vol. 79, No. 19
July 11, 1980

Breaking News for Michigan Doctors

MEDIGRAM

CAPSULES

"IF ANY OF YOU HAVE concerns where I might be of help, please call or write me personally," invites MSMS President John R. Ylvisaker, MD, Pontiac, in his July Michigan Medicine column. Doctor Ylvisaker discusses the role of the medical society president, sets three priorities of his leadership term--the reimbursement system, health planning and excessive regulation--and says, "Our Society and its membership must be oriented to effecting change, not merely to living with the consequences of decisions made in the political arena."

In this issue . . .

is a special call to MSMS members to give initial care to the thousands of Indochinese refugees coming into Michigan. An MSMS task force will develop a list of volunteer physicians which will be carefully used to refer resettling refugees for medical care. Members who would like to help may see page 3 and its accompanying tear-out form.

* * *

The July issue of Michigan Medicine contains a special report on the Indochinese refugee situation in the state, to help those physicians who provide medical care to the refugees.

MSMS members help defeat 'deflater' clause in HB 4555

MSMS leaders are appreciative of the many members who contacted their senators in recent weeks about Blue Cross Blue Shield of Michigan reform legislation, HB 4555. MSMS members' efforts helped defeat that section of the proposed Senate bill which would have required a one percent per year reduction in the formula for BCBSM payments to providers.

The "deflater clause" was of major interest to MSMS and other health care interests, and during the course of discussions over the past two weeks was removed, returned and removed again from the Senate bill. If the clause had remained, MSMS feared the voluntary effort cost goals would most likely fail, triggering intervention into health care benefits by the state insurance commissioner.

After intense debate over the on-again, off-again amendments, the Senate July 3 finally enacted its version of HB 4555. The Senate version generally reorganizes and decreases the BCBSM board, providing that no more than 25 percent of the members can represent provider groups, makes BCBSM records more accessible to the public and the insurance commissioner, provides for automatic interim rate increases if a rate proposal is pending more than 75 days, imposes cost containment measures and increases allowable contingency reserves.

The House version enacted earlier proposes a cost containment formula mutually agreed upon by provider groups and the Health Care Cost Containment Coalition. The bill now goes to a joint Senate/House conference committee which will attempt to resolve the substantial differences between the two versions in areas other than cost containment.

At this writing it is not known whether the conference committee will begin work during the summer recess or wait until the legislature reconvenes in September.

PHYSICIANS ATTENDING the 60th anniversary meeting of the Collier Penberthy Thirlby Medical Conference July 24-25 will be brought up to date in a variety of scientific subjects. The two-day event scheduled for the Park Place Motor Inn, Traverse City, stresses dialogue between practicing physicians and university professors. MSMS President John R. Ylvisaker, MD, will be a special guest at the Thursday evening banquet. The program committee is headed by A. James French, MD, of the University of Michigan Medical School, while Kenneth H. Musson, MD, Traverse City, is chairman of arrangements.

THE PLANNING COMMITTEE for the 1981 MSMS-sponsored Michigan Conference on Maternal and Perinatal Health will meet for the first time July 16. The committee will begin to select speakers and topics for the annual conference, scheduled March 25-26 at the Hyatt Regency Dearborn.

AN OHIO COMPANY, after much negotiation with the Michigan insurance commissioner, has successfully outbid the Michigan Physicians Mutual Liability Insurance Company to take over the policies of MDs formerly with the state Brown-McNeely Fund. The Fund expired by law June 30. Physicians formerly with the Fund, however, may seek coverage with any Michigan malpractice insurer of their choice. The Fund board chose the new company, the Physicians Insurance Company of Michigan (PICOM) from several companies bidding to take over. Subsequent negotiations with the insurance commissioner then broke down until PICOM agreed to meet financial terms.

MSMS in-depth study part of current debedding action

The MSMS Steering Committee on Health Planning has begun its in-depth study of the validity of the Michigan bed reduction program, as mandated by the 1980 MSMS House of Delegates. The study is to lead to an alternative plan and/or appropriate bed reduction criteria, if MSMS feels it is needed.

In the meantime, there have been several developments in the Michigan bed reduction situation:

- 1) Gov. Milliken has signed a bill that delays the Comprehensive Health Planning Council of Southeast Michigan hospital bed reduction plan. The law provides a one-year hiatus to work out the inequities in the CHPC-SEM plan.
- 2) The Michigan legislature's Special Joint Committee on Bed Reduction has held several meetings and is taking time to digest its findings. The Committee has agreed to take some extra time to review the volumes of data received. The committee hopes to make its final recommendations during the summer recess.
- 3) President Carter has signed a memorandum which proposes to limit federal dollars for hospital construction and renovation in "overbedded areas." HSAs will be called on to develop a federally acceptable bed reduction plan based on the standard of four hospital beds per 1,000 population at a minimum 80 percent occupancy rate. If an HSA does not develop an acceptable plan, its certificate of need review function would be forfeited to the state. When a bed reduction plan is developed and approved, the federal government would withhold monies, including Medicaid and Medicare, from any hospital that is not in compliance.

AMA delegates have four goals

Michigan's AMA delegates plan a busy few days at the coming AMA annual meeting July 20-24 in Chicago. The delegates, with Robert E. Rice, MD, Greenville, delegation chairman, will introduce four resolutions to the AMA House of Delegates.

The resolutions:

- 1) Call for the AMA to reaffirm its stand against special and preferential subsidies to one form or another of health and medical care,
- 2) Call for the AMA to reaffirm its support for the PSRO program, do whatever it can to assure sufficient PSRO finances and urge AMA members to participate in PSROs,
- 3) Call for the AMA House to urge its members to resist by all legal means governmental encroachments on AMA member's medical ethics standards, and
- 4) Commend the AMA board of trustees for its efforts so far, and urge it to continue working to resolve the national schism in CME accreditation bodies.

Sign form below to volunteer to aid Indochinese refugees in Michigan

Because it is essential for Indochinese refugees in Michigan to receive prompt medical attention, the MSMS Task Force on Indochinese Refugees is compiling a list of physicians who are willing to see these new American residents.

Relief agencies have told MSMS that it is sometimes difficult to find a physician to see the resettled refugees.

What is your commitment?

The names of physicians who complete and mail the attached form will be placed on a list of those who will provide care for Indochinese refugees for initial screening or for urgent care. It is the physician's decision whether to accept these individuals on a permanent basis. The list will be kept by MSMS or the county medical society, and calls will be referred to physicians on the list on a rotating basis. MSMS has alerted county society presidents and executives to this new

project, and asked their help. Physicians may remove their names from the list at any time by calling MSMS. Sponsors of refugee families will be told to call the county or state medical society to get the name of a physician.

Why is this necessary?

There are 6,000 Indochinese refugees in Michigan now, and another 6,000 are anticipated within 18 months. These people arrive in America with severe health problems, but, for a variety of reasons, are falling through the cracks in the health care delivery system. In the best humanitarian traditions of the medical profession, MSMS is trying to assure that those who desperately need medical attention can obtain it without undue delay.

Thank you.

Hector J. Inchaustegui, MD, chairman
MSMS Task Force on Indochinese Refugees

Yes, I would be willing to see resettled Indochinese refugees in my area for initial medical screening or urgent care. I understand it is my decision whether to provide the refugees with continued care. Please place my name on the physicians available list.

Name_____

Address_____

City_____ Zip_____

Specialty_____

Please tear off completed form and mail to:

MSMS
Box 950
120 W. Saginaw St.
East Lansing, MI 48823

MICHIGAN PHYSICIANS SUPPORTING PSROs are urged to write their congressmen and senators soon recommending the PSRO program be continued and strengthened. Action is particularly crucial now, as Charles Rangle (D-NY), chairman, House Ways and Means Health Subcommittee, will conduct hearings during the last week of July and early August to determine whether the PSRO program should be repeated. Further House appropriations activity on the PSRO 1981 funding level probably will be postponed until after this discussion.

The MSMS House of Delegates resolved to support the PSRO program and recommended intensified efforts to secure adequate congressional funding. Daniel J. Fall, MD, MSMS representative to the Statewide PSR Council, urges MDs to include the contributions of the local PSRO to quality and cost-effective health care in any statement of support. Physicians may contact local PSROs or Sherry Wellman at MSMS for help.

THE MICHIGAN DOCTORS' MEDICAL Seminars are planned Feb. 20-27 and March 20-27, 1981, at Snowmass ski resort, Colorado. The medical program is planned as usual to allow for skiing time. Interested physicians should contact Richard Campau at MSMS.

Abortion issue again clouds Medicaid appropriations future

The annual controversy between Governor Milliken and the legislature over state-funded abortions may cause the Medicaid physician reimbursement account to be depleted as early as July 19. Although the legislature did enact a supplemental appropriations bill to fund Medicaid providers through the remainder of the fiscal year, Sept. 30, a prohibition against abortions was attached to the line items for physicians, hospital and pharmaceutical services. The Governor is certain to veto this prohibition. Given the manner in which the anti-abortion clauses are written, the only way the Governor can veto the prohibition is to veto all of the funds appropriated for physician, hospital and pharmaceutical services.

Since the legislature is not scheduled to return until Sept. 3, state budget officials will have to make a policy decision whether to halt payments to physicians, hospitals and pharmacists or to defer other funds into those accounts by returning bookkeeping methods to cash accounting rather than the current accrual procedure. Even if the change in accounting takes place, the additional funds would only be sufficient for those providers until the end of August. Funding for the fiscal year beginning Oct. 1 will face a similar battle since the Senate-passed budget bill for Medicaid contains the same abortion prohibition. The House has yet to act on its version of the appropriations bill.

Council at Midsummer meeting

The MSMS Council meets in its annual two-day Midsummer session as this Medigram goes in the mail. The July 11-12 meeting is at the Holiday Inn, Marquette. The Council will conduct special discussions Friday afternoon on MSMS position and policy issues. Other items on the agenda include progress reports by the Long-Range Planning Committee and Task Force on MSMS Structure; a report on the status of FTC litigation, and a discussion on medical fraud and abuse.

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MICHIGAN MEDICINE

July 1980

JOURNAL OF THE MICHIGAN STATE MEDICAL SOCIETY

Vol 79, No 20



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Who to call at MSMS headquarters

Advertising (in <i>Michigan Medicine</i>)	Bonnie Groff
AMA Delegation	Bruce Ambrose, Wayne Burmeister
Annual Scientific Meeting	
Program	Sherry Fent
Meeting Arrangements	Marce Ireland
Arbitration	Bill Madigan
Auto Lease Plan	Wayne Burmeister
Blue Cross Blue Shield	John Richards
Board of Medicine	Kevin Kelly
Continuing Medical Education	
Accreditation	Marce Ireland
Category I Calendar (for <i>Michigan Medicine</i>)	Bonnie Groff
MSMS-Sponsored Conferences	Sherry Fent
Dues Payments	Jerry Trahan
Financial Operations	Dick Campau
Foreign Medical Graduates	Mert Scholten
Governmental Agencies Liaison	Sherry Wellman
Health Career Information	Mert Scholten
HMOs (Health Maintenance Organizations)	John Richards
HSA Support Center	Dennis Paradis
Impaired Physicians	Marcelyn Ireland
Jail Health Project	David Schut
Judicial Commission	Vada Davis
Legislation	Bruce Ambrose
Maternal Health Committee and Conference	Katie Brewbaker
Medicaid	Sherry Wellman
Medical Assistants	Caroline Rich
Medical Auxiliary	Caroline Rich
Medical Care Costs	John Richards
Medical Ethics	Vada Davis
Medigram	Judy Marr
Meeting Information (National, State)	Bonnie Groff
Member Services	Wayne Burmeister
Membership Records	Peg Berry
Michigan Association for Medical Education	Meredith Fors
Michigan Doctors Political Action Committee	Kevin Kelly
<i>Michigan Medicine</i> (MSMS Journal)	Judy Marr
Michigan Psychiatric Society	Helen Schulte
Michigan Society of Anesthesiologists	Meredith Fors
Michigan Society of General Surgeons	Caroline Rich
Michigan Society of Respiratory Therapists	Caroline Rich
MSMS Committee Meeting Schedule	Katie Brewbaker
MSMS House of Delegates	
Agenda and Schedule	Dick Campau
Meeting Arrangements	Marce Ireland
MSMS-Sponsored Insurance Programs (Life, Health, etc.)	Wayne Burmeister
MSMS Travel Programs	Marce Ireland
MSMS News Relations	Mert Scholten
Physician Hospital Relations	Dick Campau
Physician Legislative Network	Kevin Kelly
Physician Service Group	John Anthony
Practice Management Seminars	John Anthony
Professional Liability Insurance	Bill Madigan
PSRO	Sherry Wellman
Socio-Economic Surveys	John Richards
Specialty Societies	
Information	Katie Brewbaker
Council of Specialty Societies	Bill Madigan
Third Party Payors	John Richards

MSMS ADDRESS: Michigan State Medical Society MSMS PHONE: 517/337-1351
120 West Saginaw (Box 950)
East Lansing, MI 48823

It's a far cry from southeast Asian refugee camps to Michigan towns and cities. There's much to be done in health care for those making the journey, like the little boy on the cover. This month's special section is dedicated to aid Michigan physicians in providing refugees' health care. (Cover photo by James W. Jordan, Jr.)

MICHIGAN MEDICINE

July 1980, Volume 79, Number 20

Special report

- 357** With several thousand Vietnamese, Laotians, and Cambodians resettling in Michigan, the MSMS Task Force on Indochinese Refugees presents a roundup of materials to help Michigan physicians who may have the new Americans among their patients. Medical and cultural materials and one Michigan MD's personal experiences are included in this first part of a new *Michigan Medicine* series; Louis R. Zako, MD; Pat Hepp

Features

- 361** Effects of recession on physicians' practices; David M. Schut
- 362** MSMS Annual Scientific Meeting includes latest on chronic pain treatments
- 372** Meet MSMS/Physician Service Group, Inc., staff members
- 374** Kalamazoo physicians assess health care response to tornado disaster; Judith Marr
- 384** Michigan pediatric neurologist has specimens from 60 percent of the plant world; Nancy Nowack
- 385** Doctor Annis says physicians can do much to forestall legislative intrusions; Willah Weddon
- 392** Complete list of MSMS committee members

Departments

- 352** Editorial; Charles L. Oppy, MD
- 353** Letters
- 366** Health planning update
- 369** Peer review exchange
- 370** News
- 379** Views; George A. Dean, MD; John Valantieus, MD
- 389** New members
- 398** Meetings
- 400** Category I courses
- 402** Deaths
- 403** Classified
- 403** Ad Index
- 404** President's page; John R. Ylvisaker, MD

MDs must blame themselves if government takes over

By Charles L. Oppy, MD, Roscommon



For the past five decades medicine, as a profession, has undergone attacks from every side. It has been used as a whipping post by self-serving politicians, bureaucrats and any other individuals who wish to gain by having their names in print or before the public. In the interval, the practice of medicine has been gradually eroded so that arms of government now tell us who can be treated in hospitals, how long they can stay and, in retrospect, whether treatments came up to government dictated standards.

Others, under the label of consumerism, have attempted to increase their stature by making the doctor appear less important to the health and well being of our citizens.

Through all this, the vast majority of doctors have labored on to care for their patients in an ethical and skillful way. They appear to feel that if they do their duties in the individual case, somehow the practice of medicine in its entirety will survive and improve despite the multitude of "slings and arrows" constantly launched against it. There also seems to be a prevailing attitude that doctors really should not be involved in the political arena, from which most of these attacks are mounted.

A small group of politically active doctors has shown that those people involved in the legislative process will listen and learn if the doctors will take time to meet with them.

If we are to influence the lawmaking process before medicine, as we know it, becomes irrevocably altered, more physicians must become involved. If each Senator and Legislator was personally known by an interested physician the impact of the advice and counsel available to the lawmakers would be translated into the legislative process.

Being involved in the political process is more than an annual contribution to MDPAC. It means talking to legislators. It also means talking to patients and friends who elect legislators. Medicine must present its side of this continuing controversy or the public will only hear that half which benefits our attackers and harms the practice of medicine and thereby ultimately harms the public as the medical environment and quality deteriorate.

The time to become involved is now. If anyone is confused as to how to start, a simple contact with a member of the MSMS House of Delegates, Council or headquarters staff will show the way. The hour is late, but our professional independence and self-regulation can still be salvaged if we are willing to make the effort.

Doctor Oppy is chairman of the MSMS Council Committee on Legislative Policy.

Michigan State Medical Society
Warren F. Tryloff, director

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Charles L. Oppy, MD, Roscommon

Editor
Judith Marr

Michigan Medicine, the official journal of the Michigan State Medical Society, is dedicated to provide useful information for Michigan physicians about actions of the Michigan State Medical Society and contemporary issues, with special emphasis on socio-economics, legislation and news about medicine in Michigan.

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Doctor Kuiper stands by article's account of board's feelings

In response to the letter of William Ballenger, I stand by the report printed in the April, 1980 *Michigan Medicine*.

To say the least, I am disappointed in Mr. Ballenger's letter. But I am not surprised by his response.

I believe that the public would be best served if there were consultation between Mr. Ballenger and the

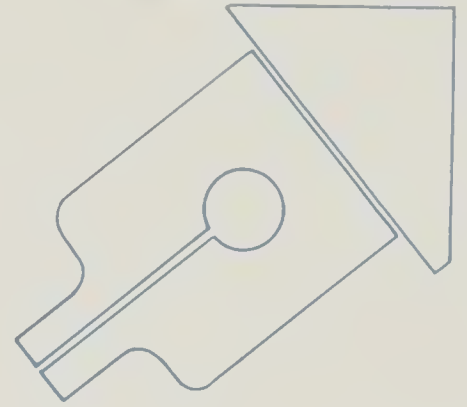
President of the Board of Medicine. Since I became President in January 1980, Mr. Ballenger has failed to return a single phone call personally in spite of the fact that I live in Lansing and am readily available to speak with him.

Mr. Ballenger quotes a *Detroit Free Press* poll which alleges that doctors are not willing or able to discipline their peers. I disagree with this allegation. The Michigan Board of Medicine is strangleheld and handicapped by the inefficient and fragmented Department of Licensing and Regulation. The Board cannot discipline anybody unless the Department of Licensing and Regulation, which Mr. Ballenger directs, conducts prompt and thorough investigations so that the Board of Medicine can act.

Under the Public Health Code, your Michigan Board of Medicine has no investigative powers. There are about 105 outstanding complaints that the Board of Medicine cannot do anything about because all these complaints are in various stages of investigation by the Department of Licensing and Regulation. Many of these complaints go back to 1977 and 1978. The Board of Medicine can act only when it has business presented to it. As appealing as it may sound, a Board of Medicine composed of 100 percent consumers cannot do any better because of the Department of Licensing and Regulation's inefficiency.

The Board of Medicine needs to have more control over its own functions. We have been continually frustrated by the fragmentation of our authority which has come about with the inefficient reorganization of the Department of Licensing and Regulation. It is unfortunate that what Mr. Ballenger calls "resistance from Board members" can only be attributed to lack of communication and inefficiency.

Donald H. Kuiper, MD
Chairperson, Michigan
Board of Medicine



BCBSM's McCue elaborates on reimbursement program

Because of the specific concerns of the MSMS House of Delegates for "understandability" regarding the new BCBSM professional reimbursement policy, I wish to offer for purposes of clarity the following comments/suggestions to the article by John A. Richards that appeared in the May issue of *Michigan Medicine* (page 246).

I noted several areas of minor discrepancies where potential misunderstandings could arise:

Regional committees

Re: the second sentence of this section of the article: The purpose of the regional committees is to receive data produced by BCBSM (as well as any other sources) on utilization and on cost patterns within the region.

These regional committees are not exclusively utilization review committees. They should be looking at both underuse and overuse and attempting to identify causes for same.

It may be found by a regional committee that there are definite "problems" in terms of overutilization and inappropriate health care costs and the causes may well be clearly identifiable. Yet, the committee may find it impossible to remedy the causes in which case the regional committee may recommend that the unusual pattern of utilization/costs be accepted by BCBSM. In any event, the so-called sanctions that may be imposed for inappropriate use or costs as recommended by regional

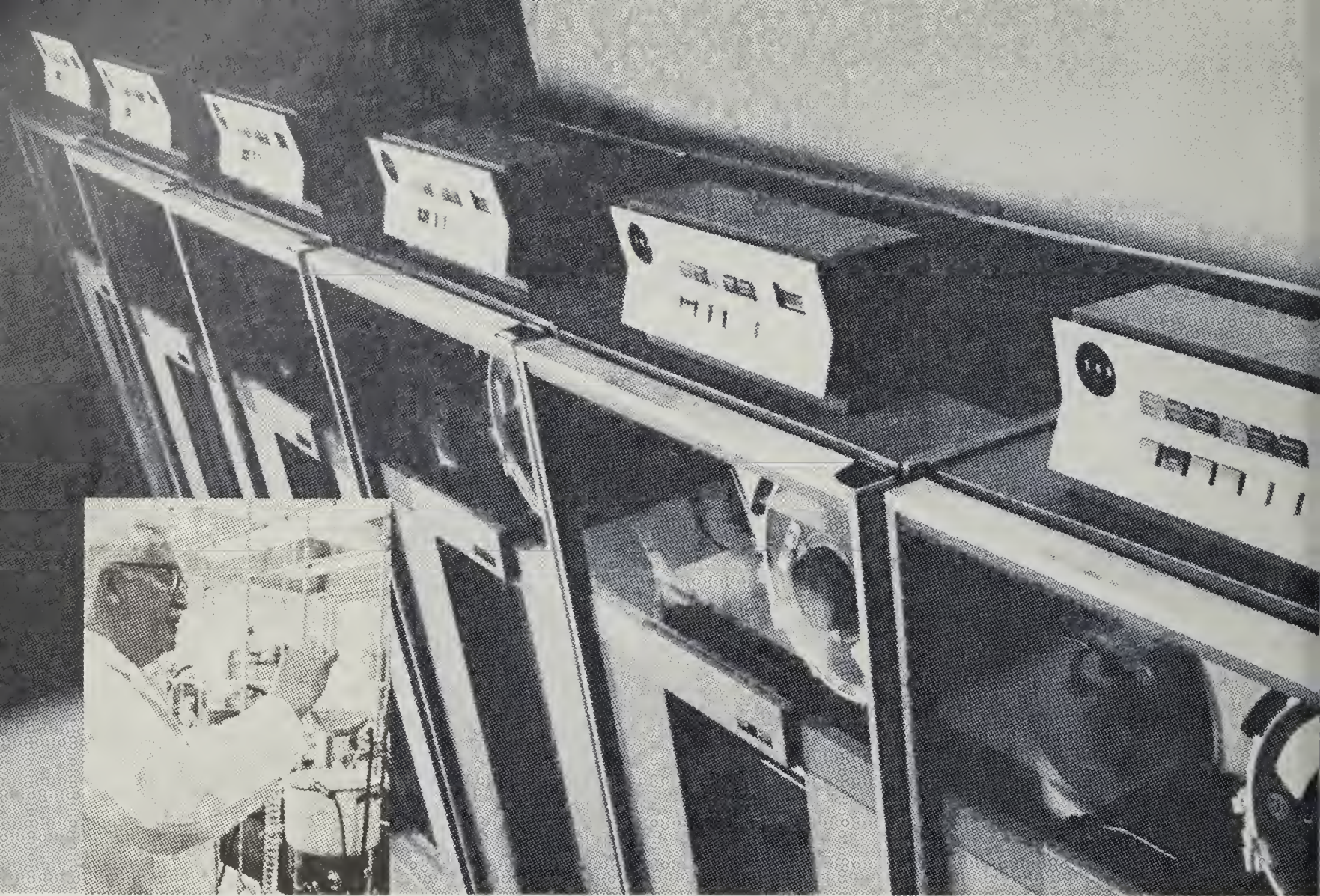
continued on page 364

Doctor Wilson thanks MSMS for Presidential award

Editor's note: The following letter was sent to MSMS Immediate Past President Ernest P. Griffin, Jr., MD, following the 1980 MSMS House of Delegates' Annual Session. Doctor Wilson is immediate past president of the Michigan Board of Medicine.

I appreciate very much the Presidential Citation presented by you April 26. It certainly is a privilege to have your colleagues appreciate the work done on the Michigan Board of Medicine. Many times it seems that we were in an adversary position with the state society, although the overall cooperation over the past eight years has been outstanding. Again my personal appreciation for the honor.

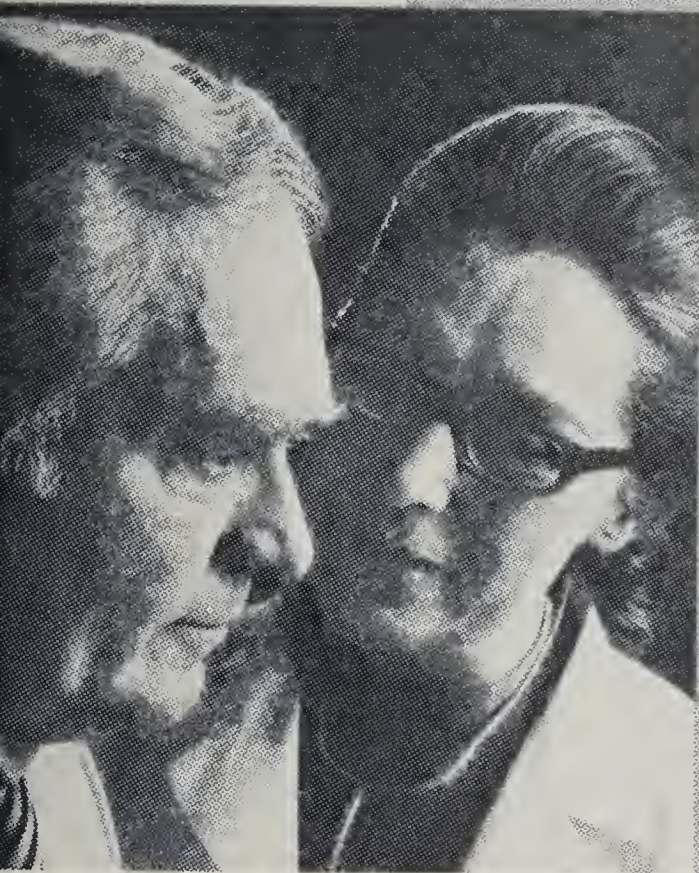
John R. Wilson, MD
Grand Rapids



proven antianxiety

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virtually free of unwanted
side effects: this was the remarkable
clinical promise of Librium (chlordiazepoxide HCl).
And today this promise continues to be
fulfilled in a wide variety of patients
you see every day.

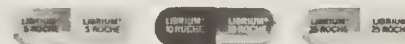
ROCHE



The published record on Librium is enormous. So large, in fact, it had to be put into a computer data bank and retrieval system. It's a record that shows Librium is highly effective in relieving anxiety; that Librium is seldom associated with serious side effects; that Librium rarely interferes with mental acuity at proper doses; that Librium is used concomitantly with primary medications. However, as with all CNS agents, patients should be warned against hazardous activities requiring complete alertness, and about possible combined effects with alcohol.

performance

Librium®
chlordiazepoxide HCl/Roche



5mg, 10mg, 25mg capsules

***synonymous
with relief
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- ☐ Minimal effect on mental acuity, in proper dosage
- ☐ Predictable patient response
- ☐ Is used concomitantly with primary medications, such as anticholinergics and cardiovascular drugs

Please see next page for summary of product information.

Librium[®] 5mg, 10mg, 25mg capsules chlordiazepoxide HCl/Roche

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Relief of anxiety and tension occurring alone or accompanying various disease states. Efficacy beyond four months not established by systematic clinical studies. Periodic reassessment of therapy recommended.

Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Warn patients that mental and/or physical abilities required for tasks such as driving or operating machinery may be impaired, as may be mental alertness in children, and that concomitant use with alcohol or CNS depressants may have an additive effect. Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported.

Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment, blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

Usual Daily Dosage: Individualize for maximum beneficial effects. *Oral—Adults:* Mild and moderate anxiety and tension, 5 or 10 mg *t.i.d.* or *q.i.d.*, severe states, 20 or 25 mg *t.i.d.* or *q.i.d.*. *Geriatric patients:* 5 mg *b.i.d.* to *q.i.d.* (See Precautions.)

Supplied: Librium[®] (chlordiazepoxide HCl) Capsules, 5 mg, 10 mg and 25 mg—bottles of 100 and 500, Tel-E-Dose[®] packages of 100, available in trays of 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10; Prescription Paks of 50, available singly and in trays of 10. Libritabs[®] (chlordiazepoxide) Tablets, 5 mg, 10 mg and 25 mg—bottles of 100 and 500. With respect to clinical activity, capsules and tablets are indistinguishable.



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It is now the charge of many Michigan physicians to care for Indochinese refugee children like the two charmers above. (James W. Jordan, Jr. photo)

SPECIAL REPORT

'Join me in this rewarding effort' — caring for resettled Indochinese refugees

By Louis R. Zako, MD, chairman, MSMS Council

MSMS is embarking on a challenging, humanistic effort to assist Indochinese refugees being resettled in Michigan. To date, there are approximately 8,000 southeast Asian refugees who are recent settlers here, and a significant number are arriving weekly.

MSMS is committed to providing its members with current information on the refugees' major medical problems and on appropriate treatment protocols.

MSMS also is committed to working with the Michigan Refugee Relief Fund to provide financial assistance, and to working with volun-

teer organizations to obtain physicians and other health care professionals who are interested in serving tours of duty in southeast Asia for varying periods of time.

MSMS involved

With this issue of *Michigan Medicine*, we begin a major new series of articles which will provide medical and cultural information to those physicians who are caring for southeast Asian refugees.

When the MSMS Council became aware of the significant number of refugees being resettled in Michigan, it made the decision, in the

finest tradition of our profession, to take steps to insure that these refugees obtained necessary medical care.

The Council appointed a Task Force on Indochinese Refugees to lead the Society's efforts. This task force is chaired by Hector Inchaustegui, MD, Royal Oak. This and forthcoming articles in *Michigan Medicine* are sponsored by the task force.

As a medical society and as a profession we're committed to providing good medical care for all Americans, whether long-term citi-

continued on page 360

Learning English, finding work refugees' two biggest challenges

By Patricia Hepp, Lansing



Many refugees leave camps like this one and are on Michigan soil within days. (James W. Jordan Jr. photo)

The current Indochinese refugee population in the United States is 346,859 as of April 30, 1980. The State of Michigan has 6,061 of these refugees whose home countries are Laos, Cambodia and Vietnam. With present immigration policy allowing 14,000 Indochinese refugees a month into the United States, it is realistic to double their present population in projections.

No accurate description can be given of a typical Indochinese refugee. Some are fluent in English and have PhDs; others are illiterate in their own language. Skills vary from professional to fisherman, farmer or foot soldier. A tribal-hill person brings a far different past to the United States than the sophisticated urban businessman. The ethnic back-

ground may be Hmong or Lao from Laos; ethnic Vietnamese or Chinese Vietnamese from Vietnam, and Khmer from Cambodia. The Indochinese refugees speak five or six separate and distinct languages. Their religions may be Confucian, Buddhist, Christian or Animism.

Freedom sought

Many reasons are given for why these people are leaving their homelands, but the most often given reason is "freedom." Half die before they reach their first country of asylum. Those who survive "the escape" may wait months or years in a refugee camp to be resettled.

The United States requires that refugees have a sponsor in the United States before they are accepted. Refugees are interviewed five times and may be disqualified for entry at any one of the interviews. If all requirements are met for entry, the refugees leave the transit camps in Thailand, Malaysia or other Asian countries on a flight to the US west coast. They

may stay overnight on the west coast or arrive that same day in the various cities of Michigan.

Before the refugees arrive, a sponsor has been busy making preparations for their arrival. Because refugees most often arrive with no possessions, a sponsor's commitment is taking the refugee from complete dependence to independence.

Sponsorship involves hours of volunteer time so sponsorships are best done by organizations or church groups. Sponsors are recruited by voluntary agencies. The voluntary agencies arranging most sponsorships in Michigan are Lutheran Immigration Refugee Services, Church World Service and United States Catholic Conference.

Refugees from the moment of entry into the United States have many of the same privileges as United States citizens; for example, they receive social security numbers and are eligible for assistance programs. However, refugees are not eligible for full United States citizenship until they have lived in the United States for five years. Their immigration status can be changed from "parolee" status after one or two years in the United States to "permanent resident alien," and finally to full citizenship.

Most difficult

Perhaps the two most difficult challenges that most refugees meet in the US are learning English and finding suitable employment. Excellent English classes are held in many locations throughout the state. Agencies dealing with specific social services for Indochinese aid them in cultural counseling and many other areas to assist the refugees in becoming independent. These people are the survivors of their cultures, and find it most difficult not to be independent in their new culture.

Many differences exist between Asian and American cultures, but our basic humanity is shared. Tears are shed when parents are reunited with their four- and six-year-old sons at Lansing Capitol City Airport after being separated for three years.

The hope of many refugees is to keep the best of their culture and learn the best of ours. If they are successful, we old Americans can look to these new Americans for some answers on how to live life.

Ms. Hepp is director, Indochinese Refugee Services, a sponsoring, social service agency for Indochinese Refugees and a program of Catholic Social Services of Lansing.

Here are treatment protocols for parasite control in refugees

Michigan physicians caring for resettled southeast Asian refugees are encountering health problems not commonly seen in the US. Michigan Medicine offers the following information to aid those treating refugees and to help the general physician population better understand the situation.

"Many of the Indochinese refugees arrive in this country with significant health problems," says a March, 1980, special report of the Indochina Refugee Action Center, Washington, DC.

"Data provided by the US Public Health Service suggests the prevalence of the following conditions: intestinal parasites in 31 percent of the refugee population, anemia in 29 percent and skin conditions in 28 percent," says the special report.

The most commonly encountered parasites in the refugee population, and the only ones which might be expected to present a danger to the population at large, are the protozoans, i.e., *Entamoeba histolytica* and *giardia lamblia*, according to the Ingham County Health Department Newsletter, Vol. II, No. II, April, 1980.

"Both diseases can be transmitted by direct fecal-oral contamination or via food and/or water intermediaries," continues the Ingham County newsletter.

"For this reason, two population sub-groups may be considered to constitute the majority of the group at risk of propagation: food handlers and children entering day care centers. Assuming that refugees who enter the food handling professions will conform to standard practices in this country, the risks of transmission should be minimal. These diseases have also been shown to be readily transmitted at day care centers.

"Helminths (nematodes, coelenterates and flukes)," continues the newsletter, "represent no danger to the public since the eggs require a period of incubation in the soil.

Michigan has neither the kind of soil, poor sanitation systems nor the bare-foot population necessary for transmission of these parasites.

"However, an individual infested with any of these worms may suffer from a chronic, debilitating illness, which can cause anemia and contribute to malnutrition."

Michigan physicians who treat the refugees are coached by Barry Stein, PhD, coordinator, Resource Center for Refugee Resettlement, Michigan State University, to tell the refugees:

1) These parasites are common in Indochina and the refugee is not

being blamed nor looked down upon in the course of treatment;

2) These parasites can be successfully treated here because there is minimal danger of re-infection and they are not common parasites here, and

3) These parasites represent a slight danger to others but can be very harmful to the infected individual.

From the June, 1980 issue of the Ingham County Health Department Newsletter, comes the following table of intestinal parasites most frequently found in adult refugees and the recommended treatments:

ORGANISM	COMMON NAME	TREATMENT
Entamoeba histolytica Entamoeba dysenteriae Entamoeba histolytica	Amebiasis.....	Flagyl 750 mg (3 tabs) tid x 10 days — ALSO GIVE — Aralen (chloroquine phosphate) 500mg bid x 2 days followed by 3rd day) 500mg daily x 3 weeks . . .
Clonorchis sinensis	"liver fluke"	Same Rx as above . . .
Ascaris lumbricoides	"roundworm"	Vermox (mebendazole) 100-mg bid x 3 days . . .
Enterobius vermicularis	"pinworm"	Same Rx as above . . .
Ancylostoma duodenale Necator americanus	"hookworm"	Same Rx as above . . .
Strongyloides stercoralis	"threadworm"	Same Rx as above . . .
Trichuris trichiura	"whipworm"	Same Rx as above . . .
Hymenolepis nana	"dwarf tapeworm"	(Day 1) . . . Atabrine 300mg 20 min's. apart (total 900mg) . . . (Day 2, 3, 4) . . . Atabrine 100mg tid
Taenia saginata	"beef tapeworm"	Atabrine 4 doses of 200mg 10 min's. apart (800mg total) . . .
Taenia solium	"pork tapeworm"	Same Rx as above . . .
Diphyllobothrium latum	"fish tapeworm"	Same Rx as above . . .
Giardia lamblia Giardia intestinalis Lamblia intestinalis	Giardiasis.....	Flagyl 750mg (3 tabs) tid x 10 days . . .

It has been our experience, that when more than one organism is found, the above indicated medications should be given consecutively and not simultaneously.

DOCTOR ZAKO/continued

zens or newly-settled refugees. These new efforts parallel our continuing work to insure good medical care for Michigan citizens in underserved areas such as rural and inner-city sections.

MSMS leaders talked recently with James W. Jordan, Jr., Governor Milliken's urban affairs representative in Detroit, and member of a committee heading the non-profit Michigan Refugee Relief Fund begun last November at the Governor's request.

Mr. Jordan last fall toured refugee camps in Thailand with Governor Milliken, where there are an estimated 400,000 Cambodians and 70,000 other refugees. Approximately 600,000 more refugees can be found along the Thai/Cambodian border.

Mr. Jordan's tour found large-scale starvation and an estimated 13,000 orphaned children. He learned that nearly 50 percent of Cambodia's population has perished due to war and famine.

After hearing Mr. Jordan's firsthand account, MSMS pledged a cooperative effort with the Michigan Refugee Relief Fund.

I recently became personally involved in the refugee resettlement challenge and I have found it most rewarding. A local church asked me

to serve as family physician for a family of Vietnamese "boat people" they have sponsored.

This family is headed by a 26-year-old father, who previously served in the Vietnamese army, fled the country to escape the Communists, and spent several months with his family in refugee camps in Thailand.

With him are his 23-year-old wife, who is expecting; their three-year-old daughter; the father's 24-year-old, single brother; a 14-year-old brother; and 11-year-old nephew and a 25-year-old single, male cousin.

Exciting experience

Initially, I had some trepidation, as I felt insecure about my medical knowledge of the people of southeast Asia. However, I contacted the National Center for Disease Control in Atlanta and the Michigan Department of Public Health. Both provided me with valuable information on the major medical problems of Asian refugees and their management.

I found all the family members had scabies, which was easily treated. TB tests were positive, and they now are on a one-year course of isoniazid prophylaxis. None of the family members was a hepatitis carrier, though Indochinese refugees frequently are.

They had a variety of infectious

skin lesions, which have responded nicely to antibiotics. Most had multiple infectious parasitic infestations, which also are responding. Their nutritional status was surprisingly good.

When the family arrived, only the father spoke very limited English. They were on public assistance and Medicaid. Now, all family members speak passable English. The father, older brother and cousin have obtained jobs in a nearby town as welders. They are off public assistance, have Blue Cross-Blue Shield of Michigan health insurance coverage, and are paying their own rent and other bills.

I have found this family charming, industrious, proud, and obviously highly motivated to adjust to American culture and language. I'm excited over the opportunity to provide their general medical care and the mother's obstetrical care.

Most of us physicians who are involved in day-to-day care of largely white, indulged, middle-class populations are gratified when the time comes to provide medical care to truly needy people.

The articles in this section are designed to assist those physicians who join me in this rewarding effort.

MSMS supports refugee relief fund

The little Asian fellow on the cover of this issue looks happy and healthy.

To help ensure he stays that way, Governor William G. Milliken has established the Michigan Refugee Relief Fund. He requests Michigan physicians' donations to that fund.

The fund was established in November, shortly after Gov. Milliken returned from a visit to the refugee camps in southeast Asia. A non-profit organization, it provides food, medicine and supplies for the refugees in Thailand and Cambodia.

Aid is delivered directly to the refugees through a network established by Gov. Milliken while he was in Thailand and Cambodia. The Governor's Office in Detroit is coordinating activities.

MSMS has agreed officially to aid the governor in obtaining donations to the fund.

Physicians who would like to contribute should send donations to Michigan Refugee Relief Fund, Box 55-316A, Detroit, 48255. All donations are tax deductible.

Michigan's economic recession expected to affect physicians' practices

By David M. Schut, MSMS Staff

With statewide unemployment over 600,000 there is growing concern as to the effects of a severe recession on the private practitioner.

With auto worker layoffs continuing and the very real prospect of the permanent loss of significant numbers of both hourly and "white collar" jobs, physicians, as a service profession, will inevitably be affected.

Basic changes

What can the Michigan physician expect?

Briefly, there are two types of changes which will occur: first, those which will affect any small business operation, and second, changes which are specific to the practice of medicine.

Those changes which affect the MD's business operation show the need for optimum practice management.

"A majority of Michigan physicians are influenced by the auto industry, which is in its toughest time ever," states Fred Mangum, of Black and Skaggs practice management company. "As auto workers' coverage lapses, patients' ability to pay is impaired. Thus, it will be more important than ever to retain patients and treat them in a way which will ensure their continued business, and their desire to make payment in a timely way. This begins with a good front office staff, and careful attention to what I call 'the three As': availability, affability and ability," says Mr. Mangum. "And unfortunately, this is the priority order of these items as seen through the patient's eyes."

This sentiment is echoed by a Trenton family practitioner, Kenneth J. Ray, MD.

"Those physicians who constantly upgrade their operations and maintain a close check on their patients' satisfaction should have nothing to worry about," he says.



Within his own group of five physicians, Doctor Ray has noticed subtle changes already due to the economic recession.

"There is no doubt that we are seeing fewer patients per day than we used to. Patients coming in for periodic checkups, for blood pressure monitoring, PAP smears, and post-coronary EKG readings are waiting longer between visits. Physicians treating these types of problems in the main certainly will experience a more drastic decrease in patient load than those providing more acute care."

Other specialists likewise have noted changing patterns in their patient loads.

Kalamazoo Ophthalmology, a five-man group practice, has noted a decrease in number of their contact lens patients. Patients without health insurance also have delayed getting new eyeglasses for the last six months.

A number of specialties should be directly affected by the trend of patients to defer seeking care to a later date. Internists, plastic surgeons, allergists, dermatologists, and others will find their patients waiting until conditions are 'more serious.'

"Following my off day I used to see quite a few walk-in complaints," states Doctor Ray. "Now there are very few."

Many areas of one's practice must be carefully examined in light of these recessionary times. The physician might delay acquiring equipment, or lease equipment instead. Similarly, physicians might have to increase the number of procedures done with a single piece of equipment to justify its purchase.

Certainly much of the effect will depend on the public's perception of the recession. While one year ago people were subscribing to the 'buy now, before it costs more' philosophy, spending patterns have changed and now show an increased tendency towards savings. This is reflected in the observation that patients are delaying seeking treatment until a later time.

Long-range view

What can be expected over the long range? As physicians are a service profession, they must respond to a mobile population with equal mobility. Graduating medical students will have to make a careful choice of practice location, basing this choice not only on personal preference but on the increasingly more important aspect of population trends.

Perhaps the single most important ingredient for coping with the effects of the recession is the ability to remain flexible in practice style. Changes in office protocol, collection techniques, types of patients seen, and close attention to good practice management are increasingly paramount. More than ever, it is important to make sure that your patients are fully satisfied with all aspects of your services.

Michigan Medicine will continue to report on the effects of the recession in future issues. Aspects of the problem affecting Medicaid, medical equipment suppliers, and various specialties will be examined. Comments, questions and suggestions are solicited by the author, who may be contacted at MSMS' headquarters.

New assaults on chronic pain major topic of Annual Scientific Meeting

The vexing problems of chronic pain will have a major portion of the courses planned for the 1980 MSMS Annual Scientific Meeting Nov. 18-19-20 at the Hyatt Regency Dearborn.

Annual Scientific Meeting Chairman Samuel M. McMahon, MD, Lansing, and his advisory committee have arranged three half-day sessions on chronic headache, back pain and stomach pain during the three-day CME program.

(The complete list of courses, dates, times and course directors appears in the June 27 issue of *Michigan Medicine/Medigram*. There are 54 courses planned during the three days, and a maximum of 18 Category I credit hours can be awarded to physicians attending.)

Three pain courses

The course on headache will run from 8:30 a.m. to noon on Thursday. Co-course directors are Eugene Rontal, MD, and Michael Rontal, MD, both Southfield otorhinolaryngologists. They are planning to acquaint primary care physicians with the diagnosis of headache as a systemic entity. The course will break the diagnosis of headache down to its various components through lectures by a dentist, neurologist and otorhinolaryngologist. "We'd like to get rid of some of the myths about headaches," Doctor Eugene Rontal says.

"Multi-disciplinary Approach to Back Pain" is the title of the 8:30 a.m. to noon Tuesday course planned by course director James I. Ausman, MD, PhD, of the Henry Ford Hospital Department of Neurological Surgery and Neurology. The course is in-



tended to familiarize the primary care physician with neurosurgical, orthopaedic, physiatric, psychiatric and industrial viewpoints and approaches to back pain. An open panel discussion will follow 15-minute presentations from each aspect.

David S. Greenbaum, MD, of the Michigan State University College of Human Medicine Department of Medicine is course director for "The Patient with Chronic Abdominal Pain" 1:30 to 5 p.m. Tuesday. This subject again will be discussed from pathophysiological, clinical, psychiatric and management perspectives. Speakers will include a gastroenterologist, surgeon, psychiatrist and clinical psychologist. The faculty for this course will ask for case vignettes from the audience.

"There's a real need for most of us physicians to hear presentations of this type," says Doctor McMahon. "Many of the new techniques in pain management have been developed in just the last five to 10 years. Those of us who graduated before that time know little of them."

The classic drug treatments, which can be as debilitating as the pain itself and also can lead to addic-

tion, says Doctor McMahon, now are being joined by new pain relief methods. They include psychological support, exercise, neurological stimulation and retraining in life patterns.

"We all deal with situations so extreme they are hard to combat," says Doctor McMahon. "I am absolutely as interested as any other physician in learning some of the new pain control techniques."

Each of the pain control courses at the Annual Scientific Meeting will offer prescribed credits to family physicians. Most of the 54 courses are approved to do so by the American Academy of Family Physicians.

Other course topics

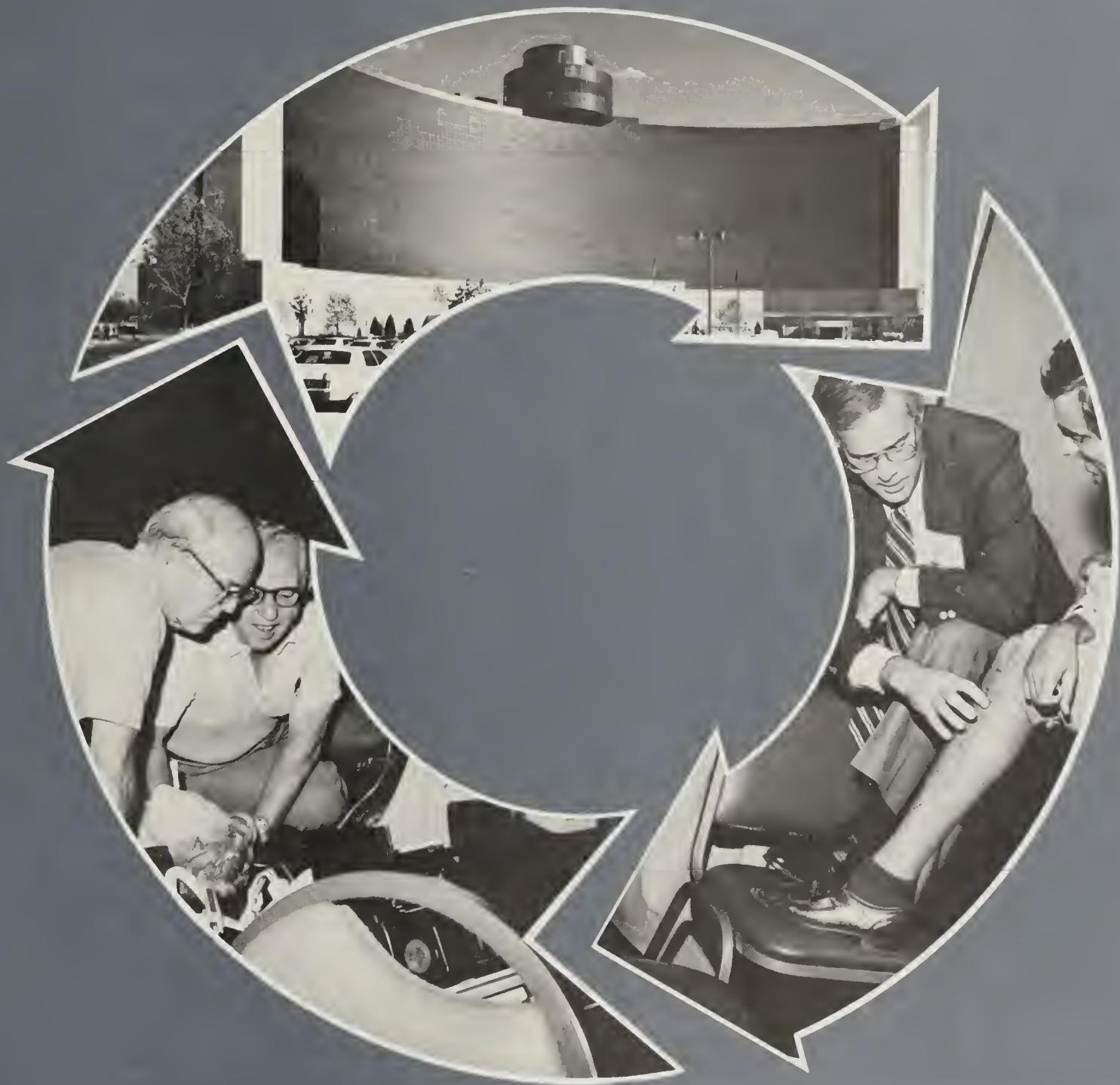
Other general medical topics which will have major portions of the program are management of emergency problems, trauma, diabetes, psychiatry, and treatment of the "whole person."

More medical problems to be discussed include arthrography and arthroscopy, cardiac arrhythmias, clinical toxicology, cancer of the lung, ischemic heart disease, renal failure, breast cancer, hypertension, local anesthetics, genito-urinary injuries, ophthalmology, office gynecology, anti-depressants and anti-anxiety drugs, and thoracic trauma.

Again, a full, two-day special course on basic and advanced cardiac life support, leading to certification in the technique, will be offered.

Future issues of *Michigan Medicine* and the *Medigram* newsletter will keep MSMS members posted on the coming CME extravaganza, with registration forms to appear in September issues.

Rx: Your CME In One Easy Dose



Your MSMS Annual Scientific Meeting is the easiest prescription for CME you ever had to take. The sweetener that makes this prescription go down easy is the schedule: two courses daily, for three days, at the Hyatt Regency Dearborn. You can choose from over 50 half-day courses and earn up to 18 hours of

Category I Credit. You'll never find a better mixture of medical subjects and fine educators. Why not prescribe a dose of CME for yourself and plan to attend.

**MSMS ANNUAL
SCIENTIFIC MEETING**
November 18-19-20, 1980
Hyatt Regency Dearborn



LETTERS/continued

committees to the state committee would not necessarily be imposed, with the expectation that the situation will be resolved in the short term. Only if a reasonable plan of improvement cannot be implemented or if implemented and unsuccessful after reasonable time would sanctions necessarily be imposed.

Maximum screens

From our past experience in using percentiles, we have noted a frequent misunderstanding of the terminology by physicians. The maximum payable amount (screen) is the 85th percentile of the aggregate statewide charges by all physicians performing a given procedure in the previous year's billings to BCBSM. In the last sentence of this section of the article, the suggestion is made that those regions above the state average will receive no increase in screens. Although that is the current position for this year, it is conceivable in future years that aberrant regions might be allowed a portion of the increase in screens depending upon circumstances.

Service incentive

The assumption is made in this section that, in order to encourage the most cost-effective location for performing a given service in a quality manner, BCBSM will increase the maximum screen in that service setting. Although not planned at this time, it is conceivable in the future that the incentive would, in fact, be a "disincentive" by lowering the amount payable in those less appropriate settings.

Profile adjustments

The second sentence of this portion of the article is a little misleading. As it reads, it seems to imply the policy in this regard has not changed. If this sentence is simply deleted from this section of the article, the balance then reads correctly.

Laboratory reimbursement

The five points in this section of the article are essentially correct with minor comments as follows:

The first point regarding the 21 automatable blood chemistry tests

has been reduced to 14 tests and the implementation date for this change in reimbursement is scheduled for July 1, 1980 as a result of litigation.

The second point regarding the reduction in the blood handling charge was implemented effective Jan. 28, 1980.

Points three and four are accurate as stated.

Point five regarding individual participation agreements for independent clinical laboratories (i.e., commercial licensed laboratories) is an item for the future with no firm effective date yet established.

MSMS concerns

The first concern deals with the reinstitution of regional screens. The article states that BCBSM "last year instituted a single (statewide) screen." Actually, this single statewide screen was implemented in 1977.

Further on, regarding cumulative increases in those areas not receiving the statewide screen because of high cost pattern problems, there is no plan at this time to offer the "cumulative" increases when such regions do reduce their high cost patterns to more average levels.

The second concern regarding the data to be used by the regional committees and the concern that physicians will be "placed in the position of defending the practice patterns of physicians they may not know" is unfounded. This is the very reason that regional committees using local physicians would best be able to evaluate local custom and practice. As stated earlier in this letter, if there is other source data involving local situations that can supplement data provided by BCBSM, we would have no objection.

I hope the foregoing comments will assist in a better understanding of our new reimbursement policies and our rationale for the changes.

Neal L. McCue
Administrative Coordinator
Professional Liaison and Support
Blue Cross Blue Shield of Michigan



Looking for MDs?

Any physician, hospital, community committee interested in recruiting one or more physicians can register its needs with the Physician Placement Service of the Michigan Health Council, 1407 S. Harrison Rd., East Lansing, 48823. The Council has 506 physicians registered as being interested in possible practice opportunities in Michigan. The executive of the MHC is Herbert A. Auer.

The primary beneficiaries of ORAL HYDERGINE[®] TABLETS, 1 mg (1 tab t.i.d.)

Each 1 mg Hydergine tablet contains dihydroergocornine mesylate 0.333 mg, dihydroergocristine mesylate 0.333 mg, and dihydroergocryptine (dihydro-alpha-ergocryptine and dihydro-beta-ergocryptine in the proportion of 2:1) mesylate 0.333 mg, representing a total of 1 mg.

They're in their late sixties, the beneficiaries of more liberal retirement laws and more enlightened attitudes toward the elderly. They're leading socially productive lives. But recently, without any clear cause, they had each begun to experience mild episodes of symptoms such as confusion, mood-depression, and dizziness. Their ability to function could have been jeopardized. That's when they became the beneficiaries of oral Hydergine therapy.



The still-functioning geriatric can benefit from Hydergine treatment

It is quite common for cognitive and emotional symptoms of deterioration to manifest gradually in the elderly. During this early stage, such symptoms are mild and more amenable to treatment. It is at this stage that Hydergine therapy has proved most effective. Patients tend to respond better, and with symptoms effectively relieved—or at least their progression retarded—the ability to function can be maintained.

Oral Hydergine tablets promote better patient compliance

Compared with the sublingual form, dosage administration is easier, with less need for supervision.

Contraindications: Hypersensitivity to the drug.

Precautions: Because the target symptoms are of unknown etiology, careful diagnosis should be attempted before prescribing Hydergine tablets and sublingual tablets.

Adverse Reactions: Serious side effects have not been found. Some sublingual irritation, transient nausea, and gastric disturbances have been reported. Hydergine tablets and sublingual tablets do not possess the vasoconstrictor properties of natural ergot alkaloids.

Dosage and Administration: 1 mg three times daily. Alleviation of symptoms is usually gradual and results may not be observed for 3–4 weeks.

How Supplied: Hydergine tablets (for oral use) 1 mg, packages of 100 and 500.

Hydergine sublingual tablets 1 mg, containing dihydroergocornine mesylate 0.333 mg, dihydroergocristine mesylate 0.333 mg, and dihydroergocryptine (dihydro-alpha-ergocryptine and dihydro-beta-ergocryptine in the proportion of 2:1) mesylate 0.333 mg, representing a total of 1 mg; packages of 100, 500, and 1000. Hydergine sublingual tablets 0.5 mg, containing dihydroergocornine mesylate 0.167 mg, dihydroergocristine mesylate 0.167 mg, and dihydroergocryptine (dihydro-alpha-ergocryptine and dihydro-beta-ergocryptine in the proportion of 2:1) mesylate 0.167 mg, representing a total of 0.5 mg; packages of 100 and 1000.

Before prescribing, see package insert for full product information.

SANDOZ PHARMACEUTICALS, EAST HANOVER, N.J. 07936



HEALTH PLANNING UPDATE

By Dennis Paradis, Director
MSMS Physician/HSA Support Center



Appropriateness review

Health systems agencies (HSAs) now can perform a new kind of review as part of their regulatory functions.

HSAs soon will begin to review the "appropriateness of institutional health services" and make recommendations. These findings will be made public, and a plan for remedial action will be proposed when a service is determined to be "inappropriate."

Services to be reviewed are: end stage renal disease, neonatal, obstetric, acute care medical/surgical, pediatric, long-term care and home health services. Appropriateness review is for critiquing existing services and facilities, in contrast to the already-established HSA certificate of need system which regulates the growth of new construction and service capacity.

Any comments or questions physicians may have with respect to appropriateness review may be directed to the MSMS Physician/HSA Support Center.

EMS categorization

MSMS is proposing new categories for emergency medical services to replace the controversial existing format. The new categories are to be discussed by the MSMS Council at its July 10-13 meeting, and will make two major improvements over the existing format.

First, they recognize the contribution of small, rural hospitals which do not fare well under the current EMS categories. Second, they eliminate the previous requirements for certain levels of medical care capabilities in both emergency room and the rest of the hospital, and allow hospitals greater recognition for services in which they can provide expertise.

The Michigan Hospital Association and the Michigan Department of Public Health have reacted favorably to MSMS' proposed new EMS categories.

Bed need study underway

Pursuant to House of Delegates Resolution 19-80A, MSMS staff has begun a study to examine the issue of excess hospital beds in Michigan. The proposed study outline calls for focusing on two major areas: 1) identifying excess hospital beds and 2) determining the cost containment potential in eliminating excess hospital beds. The proposed date for the conclusion of the study is Sept. 30.

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Brief Summary

INDICATION: Tenuate and Tenuate Dospan are indicated in the management of exogenous obesity as a short-term adjunct (a few weeks) in a regimen of weight reduction based on caloric restriction. The limited usefulness of agents of this class should be measured against possible risk factors inherent in their use such as those described below.

CONTRAINDICATIONS: Advanced arteriosclerosis, hyperthyroidism, known hypersensitivity, or idiosyncrasy to the sympathomimetic amines, glaucoma. Agitated states. Patients with a history of drug abuse. During or within 14 days following the administration of monoamine oxidase inhibitors, (hypertensive crises may result).

WARNINGS: If tolerance develops, the recommended dose should not be exceeded in an attempt to increase the effect, rather, the drug should be discontinued. Tenuate may impair the ability of the patient to engage in potentially hazardous activities such as operating machinery or driving a motor vehicle, the patient should therefore be cautioned accordingly. **Drug Dependence:** Tenuate has some chemical and pharmacologic similarities to the amphetamines and other related stimulant drugs that have been extensively abused. There have been reports of subjects becoming psychologically dependent on diethylpropion. The possibility of abuse should be kept in mind when evaluating the desirability of including a drug as part of a weight reduction program. Abuse of amphetamines and related drugs may be associated with varying degrees of psychological dependence and social dysfunction which, in the case of certain drugs, may be severe. There are reports of patients who have increased the dosage to many times that recommended. Abrupt cessation following prolonged high dosage administration results in extreme fatigue and mental depression; changes are also noted on the sleep EEG. Manifestations of chronic intoxication with anorectic drugs include severe dermatoses, marked insomnia, irritability, hyperactivity, and personality changes. The most severe manifestation of chronic intoxications is psychosis, often clinically indistinguishable from schizophrenia. **Use in Pregnancy:** Although rat and human reproductive studies have not indicated adverse effects, the use of Tenuate by women who are pregnant or may become pregnant requires that the potential benefits be weighed against the potential risks. **Use in Children:** Tenuate is not recommended for use in children under 12 years of age.

PRECAUTIONS: Caution is to be exercised in prescribing Tenuate for patients with hypertension or with symptomatic cardiovascular disease, including arrhythmias. Tenuate should not be administered to patients with severe hypertension. Insulin requirements in diabetes mellitus may be altered in association with the use of Tenuate and the concomitant dietary regimen. Tenuate may decrease the hypotensive effect of guanethidine. The least amount feasible should be prescribed or dispensed at one time in order to minimize the possibility of overdosage. Reports suggest that Tenuate may increase convulsions in some epileptics. Therefore, epileptics receiving Tenuate should be carefully monitored. Titration of dose or discontinuance of Tenuate may be necessary.

ADVERSE REACTIONS: **Cardiovascular:** Palpitation, tachycardia, elevation of blood pressure, precordial pain, arrhythmia. One published report described T-wave changes in the ECG of a healthy young male after ingestion of diethylpropion hydrochloride. **Central Nervous System:** Overstimulation, nervousness, restlessness, dizziness, jitteriness, insomnia, anxiety, euphoria, depression, dysphoria, tremor, dyskinesia, mydriasis, drowsiness, malaise, headache; rarely psychotic episodes at recommended doses. In a few epileptics an increase in convulsive episodes has been reported. **Gastrointestinal:** Dryness of the mouth, unpleasant taste, nausea, vomiting, abdominal discomfort, diarrhea, constipation, other gastrointestinal disturbances. **Allergic:** Urticaria, rash, ecchymosis, erythema. **Endocrine:** Impotence, changes in libido, gynecomastia, menstrual upset. **Hematopoietic System:** Bone marrow depression, agranulocytosis, leukopenia. **Miscellaneous:** A variety of miscellaneous adverse reactions has been reported by physicians. These include complaints such as dyspnea, hair loss, muscle pain, dysuria, increased sweating, and polyuria.

DOSAGE AND ADMINISTRATION: Tenuate (diethylpropion hydrochloride): One 25 mg. tablet three times daily, one hour before meals, and in mid evening if desired to overcome night hunger. Tenuate Dospan (diethylpropion hydrochloride) controlled-release: One 75 mg. tablet daily, swallowed whole, in mid morning. Tenuate is not recommended for use in children under 12 years of age.

OVERDOSAGE: Manifestations of acute overdosage include restlessness, tremor, hyperreflexia, rapid respiration, confusion, assaultiveness, hallucinations, panic states. Fatigue and depression usually follow the central stimulation. Cardiovascular effects include arrhythmias, hypertension or hypotension and circulatory collapse. Gastrointestinal symptoms include nausea, vomiting, diarrhea, and abdominal cramps. Overdose of pharmacologically similar compounds has resulted in fatal poisoning, usually terminating in convulsions and coma. Management of acute Tenuate intoxication is largely symptomatic and includes lavage and sedation with a barbiturate. Experience with hemodialysis or peritoneal dialysis is inadequate to permit recommendation in this regard. Intravenous phenolamine (Regitine®) has been suggested on pharmacologic grounds for possible acute, severe hypertension, if this complicates Tenuate overdosage.

Product Information as of April, 1976

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References: 1. Citations available on request from Medical Research Department, MERRELL-NATIONAL LABORATORIES, Cincinnati, Ohio 45215. 2. Hoekenga, M.T., O'Dillon (Dillon), R.H., and Leyland, H.M. A comprehensive review of diethylpropion hydrochloride. In, Central Mechanisms of Anorectic Drugs, S. Garattini and R. Samanin, Ed., New York, Raven Press, 1978, pp 391-404.

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Indications: Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:

"Possibly" effective: as adjunctive therapy in the treatment of peptic ulcer and in the treatment of the irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis.

Final classification of the less-than-effective indications requires further investigation.

Contraindications: Glaucoma, prostatic hypertrophy, benign bladder neck obstruction; hypersensitivity to chlordiazepoxide HCl and/or clidinium Bromide.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants, and against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Physical and psychological dependence rarely reported on recommended doses, but use caution in administering Librium[®] (chlordiazepoxide HCl/Roche) to known addic-

tion-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions) reported following discontinuation of the drug.

Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy. Advise patients to discuss therapy if they intend to or do become pregnant.

As with all anticholinergics, inhibition of lactation may occur.

Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules/day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such as MAO inhibitors, phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions reported in psychiatric patients. Employ usual precautions in treating anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation reported very rarely in patients receiving the drug

and oral anticoagulants; causal relationship not established.

Adverse Reactions: No side effects or manifestations not seen with either compound alone reported with Librax. When chlordiazepoxide HCl is used alone, drowsiness, ataxia, confusion may occur, especially in elderly and debilitated; avoidable in most cases by proper dosage adjustment, but also occasionally observed at lower dosage ranges. Syncope reported in a few instances. Also encountered: isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent, generally controlled with dosage reduction, changes in EEG patterns may appear during and after treatment blood dyscrasias (including agranulocytosis), jaundice, hepatic dysfunction reported occasionally with chlordiazepoxide HCl, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax typical of anticholinergic agents, i.e., dryness of mouth, blurring of vision, urinary hesitancy, constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.

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Physicians working through PSROs can help find avenues to quality care

By Frederick W. Van Duyne, MD Flint

The Peer Review Organization of Genesee, Lapeer, Shiawassee Counties (PRO-GLSC) has been an active, conditional PSRO for five years.

Its member physicians yearly monitor 100 cases and present to each hospital the monitoring outcome. The monitor assesses such areas as the efficiency and quality of the review process and medical care delivery.

As a result, PRO-GLSC has adopted review by severity of illness and intensity of service and is now working closely with hospital medical staffs and administration to solve problems in areas such as:

- 1) Delay in consultation response,
- 2) Failure to initiate discharge planning early in the course of hospitalization,
- 3) Quality of care,
- 4) Appropriate use of ancillary services, and
- 5) Surgical or diagnostic cases that could be done on an ambulatory basis.

PRO-GLSC effective

Since the beginning of this active PSRO scrutiny, local physicians

Doctor Van Duyne is president of the PRO-GLSC and vice president of the Statewide Professional Standards Review Council.

In this month's column, a PSRO leader describes his organization's activities and commitments. Future "Peer Review Exchange" columns will continue the descriptions of individual PSROs' efforts.

have greatly improved their medical records, and thus patient care.

Approximately 125 cases involving questions on quality of care are referred to the appropriate medical staff committees of the hospitals in a normal three-month period. In the past, we did little to identify, much less modify, the practice patterns of the relatively few physicians who account for the majority of these quality referrals.

We now require a response by the hospital. Hospitals have taken corrective action in several instances, resulting in loss of staff privileges or close monitoring of a physician's work by a hospital staff member.

For the first time, local physicians are setting minimum standards of care for all physicians. Hospital boards of trustees who are ultimately liable for the quality of work done by the medical staff also benefit greatly from this process.

More to do

There is, however, more that can be accomplished by physicians through a PSRO. By working closely with local planning agencies, a PSRO can provide data and physician contributions to create imaginative, new medically-logical alternatives to health care delivery at a more reasonable cost.

To do this more effectively, PSROs must become involved in a review of extended care and ambulatory care, where the majority of medical services are delivered.

We know what happens to the hospitalized patient but have little idea of the quality of care received after discharge.

PSRO can help find solutions to

problems such as: 1) the quality of care provided in extended care facilities and its relationship to its current reimbursement by third parties, 2) the delay in transfer of patients from hospitals to extended care facilities because of lack of extended care beds, 3) the absence of coordinated levels of care between hospitals and extended care facilities and between extended care facilities and home care, 4) greater use of ambulatory and office surgery where medically feasible, and the relationship of inadequate reimbursement to this problem, 5) the over-use of the emergency room.

Unique alliance

It is true that PSRO was created by federal law and that PSRO is accountable to federal and state governments.

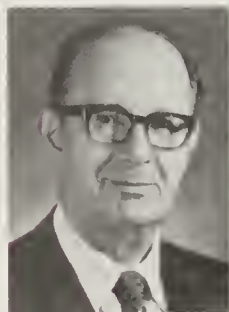
However, the medical decisions made, the criteria used, the standards adopted and the corrective action taken by a PSRO are made by physicians.

This is a unique alliance between government and physicians in behalf of the most important part of the system — the patient. We are charged with assuring that the patient is getting good quality medical service at the most reasonable cost.

If PSROs are judged from this perspective, then the importance of working for their success is obvious. These problems will be addressed and solutions will be imposed by someone or some agency or committee.

The future health of the American citizen is best served if that someone remains a practicing physician.

By Bonnie L. Groff, MSMS staff



Friedlaender



Henderson



Kelley



Purcell

An oil portrait of **Andrew D. Hunt, Jr., MD**, founding dean of the College of Human Medicine at Michigan State University, was unveiled at a special ceremony May 16. As the first dean of the College of Human Medicine, Doctor Hunt was instrumental in organizing and directing Michigan's first new medical school in more than 100 years. . . . New president of the Michigan Association of Osteopathic Physicians and Surgeons, Inc. is **Raymond E. Huldin, DO**, Grandville. . . . **William N. Hubbard, Jr., MD**, is new chairman of the board of the Pharmaceutical Manufacturers Association. . . . **Henry A. Kallet, MD**, Jackson, has been appointed by Governor Milliken to the Health Facilities and Agencies Advisory Commission. . . . At a recent meeting, the Michigan Hospital Association Board of Trustees commended **Vergil N. Slee, MD**, for his pioneering efforts in the field of biomedical statistics and for past leadership given to the Commission on Professional and Hospital Activities. . . . New secretary of the American Roentgen Ray Society is **Raymond A. Gagliardi, MD**, Pontiac. The ARRS was founded to promote scholarship, continuing education and continuing scientific and professional development of its membership. . . . **H. C. Tien, MD**, Lansing, is new president of the Greater Lansing United Nations Association. . . . **Charles H. Brown, MD**, Wyandotte, won the Boston Marathon for entries over 60 years of age. . . . **Conrad R. Lam, MD**, was honored at the annual meeting of the American Association for Thoracic Surgery for his pioneer work in induced cardiac arrest and early use of heparin. . . . **Robert Allaben, MD**, is new president of the Detroit

Academy of Surgery. . . . **Walter P. Work, MD**, was honored by some 170 friends and colleagues at a banquet given in his behalf. The banquet highlighted a two-day scientific conference for Michigan otorhinolaryngology alumni, many of whom were trained under Doctor Work. . . . **Andrew S. Watson, MD**, is recipient of the Isaac Ray Award of the American Psychiatric Association. Established in 1951, the award has been given to psychiatrists, lawyers, judges and other professionals in the human behavior field "for outstanding contributions to better understanding between psychiatry and law." . . . **William N. Kelley, MD** is new president-elect of the American Federation for Clinical Research. With over 10,000 members, AFCR is the largest organization in the United States dedicated to the advancement of clinical investigation. . . . **John W. Henderson, MD**, is new vice president of the American Ophthalmology Society. . . . **Malcolm Graham, MD**, received the American Academy of Ophthalmology and Otolaryngology award for distinguished services in educational programs. . . . New president of the Rehabilitation Institute, Detroit, is **Leonard F. Bender, MD**. He succeeds **Joseph N. Schaeffer, MD**, who is retiring after 22 years at the Institute. . . . **Brian Youngs, MD**, is new health officer/medical director in charge of both District Health Departments No. 3 and No. 4 serving Alpena, Antrim, Charlevoix, Cheboygan, Emmet, Montmorency, Otsego and Presque Isle Counties. The region has been without a medical director since February when **James T. Harrison, MD**, took a position in Lansing with the state health department. . . . **David S. Greenbaum,**

MD, is one of 10 senior faculty members at Michigan State University who received Distinguished Faculty Awards at the recent annual Faculty Awards Convocation. He was honored for "his major contribution to the development of interdisciplinary education programs in the College of Human Medicine." . . . **Thomas S. Gunnings, MD** is a new appointee to the Michigan Youth Advisory Commission. The commission informs the public and the various branches of state government of the needs and interests of children. . . . New chairman of the board of chancellors of the American College of Radiology is **John H. Harris, Jr., MD**. . . . **E. James Potchen, MD**, has been named to the policy advisory group of the National Cancer Institute in Canada. . . . **Muriel C. Meyers, MD**, Ann Arbor, was honored with a scientific symposium in her honor. The symposium in hematology, sponsored by the Department of Internal Medicine at the University of Michigan and the Simpson Institute, recognized Doctor Meyer's 36 years of service to the University, from which she is retiring. . . . New vice president of the American Laryngological, Rhinological and Otolological Society is **Bruce Proctor, MD**, Royal Oak. . . . **John A. Valantieus, MD**, president-elect of the Berrien County Medical Society, was the subject of a feature article in the South Bend Tribune. The story reviewed the many remarkable qualities and accomplishments of Doctor Val. These include the adoption of eight children and the raising of 57 foster children (see article page 382). . . . Wayne State University School of Medicine presented a three-day symposium honoring the research contributions of **Walter H. Seegers, MD**. . . . **Edward J. Treisman, MD**, Southfield, is new president of the Wayne State University School of Medicine Alumni Association. . . . New president of the American Occupational Medical Association is **Francis L. Purcell, MD**, Ypsilanti. . . . **Robert B. Talley, MD**, was re-elected chairperson of the board and president of the Commission on Professional and Hospital Activities. . . . New vice president of the American Academy of Allergy is **Sidney Friedlaender, MD**, Southfield.

DESCRIPTION: Methyltestosterone is 17 β -Hydroxy-17-Methylandrosta-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunuchism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-puberal cryptorchidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric,

avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE**

REACTIONS: Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. **In the male:** Eunuchoidism and eunuchism, 10 to 40 mg; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpuberal cryptorchism, 30 mg. **REFERENCE:** R. B. Greenblatt, M.D.; R. Witherington, M.D.; I. B. Sipahioğlu, M.D. Hormones for Improved Sexuality in the Male and the Female Climacteric. *Drug Therapy*, Sept. 1976. **SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only.

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Anthony



Fors



Heins



Keller



Rich



Schulte

This is the final in a series of articles which have profiled MSMS staff members and their duties. The series began in the November, 1979 issue of *Michigan Medicine*, and has included the MSMS Departments of Economics and Finance, Government Relations, and Member Services, the Office of the Director, and now the MSMS/Physician Service Group, Inc.

The MSMS Physician Service Group, Inc. was created to provide necessary business practice services to the MD population of Michigan.

In addition to general educational seminars for practicing MDs, residents and medical assistants, the PSG provides on-site, in-office practice management consultations. This area is being expanded and the number of physicians that have used the service numbers in the hundreds.

The Physician Service Group is active in estate planning for MDs and their spouses. The PSG also provides administrative services to seven Michigan medical organizations which contract with MSMS. It offers MSMS members a credit card bill collection service and endorses a private bill collection agency.

John H. Anthony is the general manager of the Physician Service Group, Inc. In this capacity he serves as the general supervisor of the day-to-day operations of the organizations. Policy is made by a seven-member physician board of directors, which is appointed by the MSMS Council.

Meredith Fors plays a dual role with the Physician Service Group,

Inc. She is an account executive to the Michigan Society of Anesthesiologists (450 members), and the Michigan Association for Medical Educators (170 members).

She also is the MSMS/PSG Program Coordinator. Meredith oversees and manages the newly-developed credit card program and the MSMS-endorsed I. C. Collection Service. The credit card program was developed to expedite payment of services as well as diminish accounts receivable. Meredith works closely with Mr. Anthony to develop and promote all services offered by the Physician Service Group, Inc.

Viola M. Heins is the secretary for two MSMS/PSG account executives who serve six specialty groups. She processes membership applications, dues billings, membership records, computer address corrections, membership directories, correspondence and individual meeting files.

Robin Keller is secretary to Helen Schulte, executive director of the Michigan Psychiatric Society. Along with her daily responsibilities, she is membership secretary for MPS, arranges council and committee

meetings, pre-registers MPS CME meetings, and works with printers to prepare programs and other materials for mailings to the membership.

Caroline Rich is an account executive, serving as executive secretary for the Michigan Society of General Surgeons (membership 400), Michigan State Medical Society Auxiliary (membership 2,700), the American Association of Medical Assistants, Inc., State of Michigan (membership 1,000) and the Michigan Society for Respiratory Therapy (membership 1,000). She oversees the membership processing, dues, personal files, newsletters, and convention materials; staffs meetings and takes minutes and arranges meeting facilities.

In the capacity of account executive, Helen Schulte is the executive director for the Michigan Psychiatric Society, an 893-member organization. Her services and those of Meredith Fors and Caroline Rich provide seven specialty societies with permanent address and telephone from which to handle society business efficiently and expeditiously.

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Kalamazoo triage units rush a critical tornado victim into the Bronson Methodist Hospital Emergency Department. (Photo by Larry Wolf)

Kalamazoo medics say 'fantastic' to health personnel response after tornadoes

By Judith Marr, editor

A continuous videotape was playing on a large-screen TV in Kalamazoo's Bronson Methodist Hospital lobby. Knots of hospital personnel, ambulatory patients and visitors ebbed and flowed about it, watching.

With the survivors' need for explanations, they were absorbing scenes of tornado destruction of two days earlier in their city. The film also included praise from hospital administrators and officers of employees' reactions to the sudden disaster.

"This videotape presentation is our way of thanking the hospital personnel," explained Tom Clark, Bronson director of public affairs. "Our employees reacted magnificently."

All over the city that day, May

15, physicians were echoing Mr. Clark's description of how well emergency and stand-by medical corps sprang into action after a tornado ripped up the Kalamazoo downtown. Another storm destroyed a number of homes on Kalamazoo's west side. In, all five deaths were recorded and approximately 80 were injured.

'Very pleased'

"I was very pleased with the extent of the medical corps' coordination," said Robert A. Janke, MD, family physician and chief of staff at Bronson.

He served in his appointed spot in the hospital's disaster control

center. It was there that decisions were made for which phase of the community disaster plan to effect. Contact also was maintained there with Bronson's sister facility, Borgess Hospital.

"We had no difficulty in pinpointing the location of key people," continued Doctor Janke. "I give much credit to the hospital. Every physician knew where he or she had to be."

"We thought we had a good disaster plan. Well, we proved it's a good one. It turned out we actually were over-prepared for a small disaster."

A set of fortunate circumstances made care of the Kalamazoo tornado victims go particularly smoothly. As

he tornado touched down just one block from Bronson, the monthly surgical section meeting was underway at the hospital.

"The clan was gathering as the clouds gathered," mused Doctor Janke. "We had every surgical specialty on board in plural."

In addition, all the medical subspecialties were represented as well. The tornadoes struck at approximately 4:15 p.m. when most physicians were in their offices and easily contacted for help. Many hospital employees on first shift had not left the hospital, while those on second shift had just come in. There was an unusually large number of personnel present.

"We had over 60 doctors available immediately," said Mr. Clark. Those not needed for repair work or examinations were sent to a pool area and waited to be called.

This embarrassment of riches may have created the only minor problem cited by Doctor Janke as he reviewed the experience two days later.

"They did not interfere," he said, "but initially there were a little too many in the treatment area. It might have looked like there was more confusion than there actually was."

Doctor Janke is so pleased with hospital and medical personnel's performance following the tornadoes, he said it has renewed his faith in mankind.

"There was not a single person who said they were too busy and couldn't help. It was gratifying ... I'm not speaking just of the medical personnel but of all the community."

Two of the victims were killed by the collapse of the rear, brick wall of a department store. One of the two, both women, died in the Bronson emergency room of massive, crushing injuries.

"Our teams did quite a lot of work on her — cut-downs and chest tubes," said Tom Clark. But most of the injuries were lacerations, from flying debris — "some of the deepest gashes I've seen," he continued.

Gary Maynard, MD, vice chief of staff, acted as chief control officer until Doctor Janke could arrive. He, and surgeons Paul J. Fierke, MD, and James B. Bush, MD, spearheaded the emergency room care at Bronson.

"I thought everybody did a tre-

mendous job," Doctor Maynard said. "Our major problem was the storm had knocked out the communications center at the fire department, and we kept hearing rumors of the number of casualties. We had no idea how bad things were going to be."

Victims' fear

Ambulances began bringing the injured to the closest treatment center — Bronson — within 10 minutes after the storm hit. Two physicians — James D. Gilbert, MD, and William J. Kube, MD, went right out after the storm and began searching the debris. They pulled out the two women buried under the back wall of the department store.

Four fifths of the cases required just minor sutures and close-ups, said Doctor Maynard. "A couple of patients probably will require future therapy for nerve and/or tendon involvement."

Doctor Maynard was struck by the victims' fear. "I saw more hysteria here than I saw doing triage in Vietnam," he said. "These people were very disturbed and uncertain. There was not only the shock of the disaster; but also the pressure changes were very unsettling. Our ears popped here in the hospital, and others said they felt a roaring and pounding. It was a very humbling thing."



Doctor Janke (Photo by Mert Scholten)

He, too, was impressed by the community's willingness to help.

"I think the key to the whole thing was the tremendous organization of our disaster plan," Doctor Maynard said. "Even early on, people began to follow its direction. Everyone chipped in. We had 100 percent cooperation."

"One of the major problems was trying to take care of everyone wanting to help. It was fantastic."

Disaster plan

Bronson's and Borgess' disaster plans are coordinated through the countywide Civil Defense system, according to Doctor Janke. The hospitals' plans are typical, though modified to suit the close proximity and equal size of the two hospitals.

The plan is revised once a year. All MDs in the area are assigned in the case of a disaster to one hospital or the other, depending on the location of their office and specialty.

There are three phases to the Kalamazoo disaster plan.

According to Mr. Clark, the hospitals enter Phase I, an alert stage, when notified that a disaster has occurred or is impending. Departments set up, assess their needs in personnel, equipment and supplies, and prepare themselves mentally.

Phase II is entered when there are incoming casualties, but the hos-



Doctor Maynard (Photo by Mert Scholten)



Medical personnel gather at Bronson emergency entrance to await casualties.
(Photo by Larry Wolf)

pital is able to accommodate them with the standard ER set-up, with some help. In Phase II, the hospital also develops a count of patients which could be discharged should their beds be needed. Medical personnel advanced to "Phase II plus" after the tornadoes, Mr. Clark said.

"Phase III is for all-out war," commented Doctor Janke.

When Bronson first got word from a CD station that a tornado had been sighted and was bearing down on the downtown area, Mr. Clark recalls, hospital personnel and visitors were sent to the basement cafeteria area.

Patients were moved to the corridors of the hospital, windows opened and doors shut. Nurses stayed with the patients; physicians moved among them to assess patients' needs and determine which could be moved, if necessary.

"We didn't move our criticals out of ICU; we couldn't," said Tom Clark. "It's a particularly vulnerable

area, but there's not much we can do about it."

A number of persons were waiting for care in the emergency room and stayed there; surgery was underway and continued; even a baby was delivered.

A large number of persons — 50 or so — were waiting to be admitted for elective surgery. All were sent home to mobilize the maximum number of beds.

Doctor Fierke assumed the "point" position outside the Bronson ER — he was the first to receive the injured. Doctor Maynard was right behind him to funnel the patients to the proper place for examination and repair.

Minor injuries were sent to the outpatient treatment area. One physician took charge of each patient.

Within an hour or two, 67 patients had been cared for at Bronson. Six were admitted. Another 12 to 15 were sent to Borgess to relieve the Bronson personnel.

"I can't believe the few casualties we had under the circumstances," said Robert B. Burrell, MD, deputy director of the county civil defense medical affairs unit. (One of the buildings flattened was a Catholic elementary school which had been filled with children just two hours earlier.)

Doctor Burrell was with Doctor Janke in control central. "I can't believe how well these characters reacted under fire," he said of the medical personnel.

"It was almost as though we do this every day," reiterated Tom Clark.

WHEN ANXIETY AND TENSION MAGNIFY PAIN IN MUSCULOSKELETAL DISEASE*



A non-narcotic one-two punch against pain, with concurrent relief of anxiety/tension
EQUAGESIC[®] ^{IV}
(meprobamate and ethoheptazine citrate with aspirin) Wyeth

EQUAGESIC—Abbreviated Summary

***INDICATIONS:** Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:

"Possibly" effective for the treatment of pain accompanied by tension and/or anxiety in patients with musculoskeletal disease or tension headache. Final classification of the less-than-effective indications requires further investigation.

The effectiveness of Equagesic in long-term use, i.e. more than four months, has not been assessed by systematic clinical studies. The physician should periodically reassess usefulness of the drug for the individual patient.

CONTRAINDICATIONS: Equagesic should not be given to individuals with a history of sensitivity or severe intolerance to aspirin, meprobamate, or ethoheptazine citrate.

WARNINGS: Careful supervision of dose and amounts prescribed for patients is advised, especially with those patients with known propensity for taking excessive quantities of drugs. Excessive and prolonged use in susceptible persons, e.g., alcoholics, former addicts, and other severe psychoneurotics, has been reported to result in dependence on or habituation to the drug. Where excessive dosage has continued for weeks or months, dosage should be reduced gradually rather than abruptly stopped, since withdrawal of a "crutch" may precipitate withdrawal reaction of greater proportions than that for which the drug was originally prescribed. Abrupt discontinuance of doses in excess of the recommended dose has resulted in some cases in the occurrence of epileptiform seizures.

Special care should be taken to warn patients taking meprobamate that tolerance to alcohol may be lowered with resultant slowing of reaction time and impairment of judgement and coordination.

USAGE IN PREGNANCY AND LACTATION: An increased risk of congenital malformations associated with the use of minor tranquilizers (meprobamate, chlori-

azepoxide, and diazepam) during the first trimester of pregnancy has been suggested in several studies. Because use of these drugs is rarely a matter of urgency, their use during this period should almost always be avoided. The possibility that a woman of child-bearing potential may be pregnant at the time of institution of therapy should be considered. Patients should be advised that if they become pregnant during therapy or intend to become pregnant they should communicate with their physicians about the desirability of discontinuing the drug.

Meprobamate passes the placental barrier. It is present both in umbilical-cord blood at or near maternal plasma levels and in breast milk of lactating mothers at concentrations two to four times that of maternal plasma. When use of meprobamate is contemplated in breast-feeding patients, the drug's higher concentrations in breast milk as compared to maternal plasma levels should be considered.

Preparations containing aspirin should be kept out of the reach of children. Equagesic is not recommended for patients 12 years of age and under.

PRECAUTIONS: Should drowsiness, ataxia, or visual disturbance occur, the dose should be reduced. If symptoms continue, patients should not operate a motor vehicle or any dangerous machinery.

Suicidal attempts with meprobamate have resulted in coma, shock, vasomotor and respiratory collapse, and anuria. Very few suicidal attempts were fatal, although some patients ingested very large amounts of the drug (20 to 40 gm). These doses are much greater than recommended. The drug should be given cautiously, and in small amounts, to patients who have suicidal tendencies. In cases where excessive doses have been taken, sleep ensues rapidly and blood pressure, pulse, and respiratory rates are reduced to basal levels. Hyperventilation has been reported occasionally. Any drug remaining in the stomach should be removed and symptomatic treatment given. Should respiration become very shallow and slow CNS stimulants, e.g., caffeine, Metrazol, or am-

phetamine, may be cautiously administered. If severe hypotension develops, pressor amines should be used parenterally to restore blood pressure to normal levels.

ADVERSE REACTIONS: A small percentage of patients may experience nausea with or without vomiting and epigastric distress. Dizziness occurs rarely when meprobamate and ethoheptazine citrate with aspirin is administered in recommended dosage. The meprobamate may cause drowsiness but, as a rule, this disappears as therapy is continued. Should drowsiness persist and be associated with ataxia, this symptom can usually be controlled by decreasing the dose, but occasionally it may be desirable to administer central stimulants such as amphetamine or mephentermine sulfate concomitantly to control drowsiness.

A clearly related side effect to the administration of meprobamate is the rare occurrence of allergic or idiosyncratic reactions. This response develops, as a rule, in patients who have had only 1-4 doses of meprobamate and have not had a previous contact with the drug. Previous history of allergy may or may not be related to the incidence of reactions.

Mild reactions are characterized by an itchy urticarial or erythematous maculopapular rash which may be generalized or confined to the groin. Acute nonthrombocytopenic purpura with cutaneous petechiae, ecchymoses, peripheral edema, and fever have also been reported.

More severe cases, observed only very rarely may also have other allergic responses, including fever, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anaphylaxis, stomatitis and proctitis (1 case), and hyperthermia. Treatment should be symptomatic such as administration of epinephrine, antihistamine, and possibly hydrocortisone. Meprobamate should be stopped, and re-institution of therapy should not be attempted.

Rare cases have been reported where patients receiving meprobamate suffered from aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis, and hemolytic anemia. In nearly every instance reported, other toxic agents known to have caused these conditions have been associated with meprobamate. A few cases of leukopenia during

continuous administration of meprobamate are reported, most of these returned to normal without discontinuation of the drug.

Impairment of accommodation and visual acuity has been reported rarely.

OVERDOSE: Two instances of accidental or intentional significant overdose with ethoheptazine citrate combined with aspirin have been reported. These were accompanied by symptoms of CNS depression, including drowsiness and light-headedness, with uneventful recovery. However, on the basis of pharmacological data, it may be anticipated that CNS stimulation could occur. Other anticipated symptoms would include nausea and vomiting. Appropriate therapy of signs and symptoms as they appear is the only recommendation possible at this time. Overdosage with ethoheptazine combined with aspirin would probably produce the usual symptoms and signs of salicylate intoxication. Observation and treatment should include induced vomiting or gastric lavage, specific parenteral electrolyte therapy for ketoacidosis and dehydration, watching for evidence of hemorrhagic manifestations due to hypoprothrombinemia which, if it occurs, usually requires whole-blood transfusions.

DESCRIPTION: Each Equagesic tablet contains 150 mg meprobamate, 75 mg ethoheptazine citrate and 250 mg aspirin.

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*This drug has been evaluated as possibly effective for this indication.

Wyeth Laboratories
Philadelphia, Pa 19101



FOR MODERATE PAIN

A therapeutic dose
of acetaminophen
in one tablet

A therapeutic dose
of two complementary
analgesics

The convenience and
economy of a
dosage schedule of
one tablet, every four
hours as needed



WHY NOT WYGESIC®[®] ^{IV}

(65 mg propoxyphene HCl and 650 mg acetaminophen) Wyeth

WYGESIC—Abbreviated Summary

INDICATION: For the relief of mild-to-moderate pain.
CONTRAINDICATION: Hypersensitivity to propoxyphene or to acetaminophen.

WARNINGS: CNS ADDITIVE EFFECTS AND OVERDOSAGE. Propoxyphene in combination with alcohol, tranquilizers, sedative-hypnotics, or other CNS depressants has an additive depressant effect. Patients taking this drug should be advised of the additive effect and warned not to exceed the dosage recommended. Toxic effects and fatalities have occurred following overdoses of propoxyphene alone or in combination with other CNS depressants. Most of these patients had histories of emotional disturbances or suicidal ideation or attempts, as well as misuse of tranquilizers, alcohol, or other CNS-active drugs. Caution should be exercised in prescribing large amounts of propoxyphene for such patients (see Management of Overdosage).

DRUG DEPENDENCE: Propoxyphene can produce drug dependence characterized by psychic dependence and less frequently, physical dependence and tolerance. It will only partially suppress the withdrawal syndrome in individuals physically dependent on morphine or other narcotics. The abuse liability of propoxyphene is qualitatively similar to codeine's although quantitatively less, and propoxyphene should be prescribed with the same degree of caution appropriate to the use of codeine.

USAGE IN AMBULATORY PATIENTS: Propoxyphene may impair the mental and/or physical abilities required for potentially hazardous tasks, e.g. driving a car or operating machinery. Patients should be cautioned accordingly.

USAGE IN PREGNANCY: Safe use in pregnancy has not been established relative to possible adverse effects on fetal development. **INSTANCES OF WITHDRAWAL SYMPTOMS IN THE NEONATE HAVE BEEN REPORTED FOLLOWING USAGE DURING PREGNANCY.** Therefore, propoxyphene should not be used in pregnant women unless, in the

judgement of the physician, the potential benefits outweigh the possible hazards.

USAGE IN CHILDREN: Propoxyphene is not recommended for children because documented clinical experience has been insufficient to establish safety and a suitable dosage regimen in the pediatric group.

PRECAUTIONS: Confusion, anxiety, and tremors have been reported in a few patients receiving propoxyphene concomitantly with orphenadrine. The CNS depressant effect of propoxyphene may be additive with other CNS depressants, including alcohol.

ADVERSE REACTIONS: The most frequent adverse reactions are dizziness, sedation, nausea, and vomiting. These seem more prominent in ambulatory than in nonambulatory patients; some of these reactions may be alleviated if the patient lies down.

Other adverse reactions include constipation, abdominal pain, skin rashes, light-headedness, headache, weakness, euphoria, dysphoria, and minor visual disturbances. The chronic ingestion of propoxyphene in doses over 800 mg per day has caused toxic psychoses and convulsions. Cases of liver dysfunction have been reported.

DRUG INTERACTIONS: Propoxyphene in combination with alcohol, tranquilizers, sedative-hypnotics, and other CNS depressants has an additive depressant effect. Patients taking this drug should be advised of the additive effect and warned not to exceed the dosage recommended. (see Warnings) Confusion, anxiety, and tremors have been reported in a few patients receiving propoxyphene concomitantly with orphenadrine.

MANAGEMENT OF OVERDOSAGE: SYMPTOMS The manifestations of serious overdosage with propoxyphene are similar to those of narcotic overdosage and include respiratory depression (a decrease in respiratory rate and/or tidal volume, Cheyne-Stokes respiration, cyanosis), extreme somnolence progressing to stupor or coma, pupillary constriction, and circulatory collapse. In addition to these characteristics, which are reversed by narcotic antago-

nists such as naloxone, there may be other effects. Overdoses of propoxyphene can cause delay of cardiac conduction as well as focal or generalized convulsions, a prominent feature in most cases of severe poisoning. Cardiac arrhythmias and pulmonary edema have occasionally been reported, and apnea, cardiac arrest, and death have occurred.

Symptoms of massive overdosage with acetaminophen may include nausea, vomiting, anorexia, and abdominal pain, beginning shortly after ingestion and lasting for 12 to 24 hours. However, early recognition may be difficult since early symptoms may be mild and nonspecific. Evidence of liver damage is usually delayed. After the initial symptoms, the patient may feel less ill; however, laboratory determinations are likely to show a rapid rise in liver enzymes and bilirubin. In case of serious hepatotoxicity, jaundice, coagulation defects, hypoglycemia, encephalopathy, coma, and death may follow. Renal failure due to tubular necrosis, and myocardopathy, have also been reported.

Ingestion of 10 grams or more of acetaminophen may produce hepatotoxicity. A 13-gram dose has reportedly been fatal.

TREATMENT: Primary attention should be given to the reestablishment of adequate respiratory exchange through provision of a patent airway and institution of assisted or controlled ventilation. The narcotic antagonists, naloxone, nalorphine, and levallorphan, are specific antidotes against the respiratory depression produced by propoxyphene. An appropriate dose of one of these antagonists should be administered, preferably IV, simultaneously with efforts at respiratory resuscitation and the antagonist should be repeated as necessary until the patient's condition remains satisfactory. In addition to a narcotic antagonist, the patient may require careful titration with an anticonvulsant to control seizures. Analeptic drugs (e.g. caffeine or amphetamine) should not be used because of their tendency to precipitate convulsions.

Oxygen, IV fluids, vasopressors and other supportive measures should be used as indicated. Gastric lavage may be helpful. Activated charcoal can absorb a significant amount of ingested propoxyphene. Dialysis is of little value in poisoning by propoxyphene alone. Acetaminophen is rapidly absorbed, and efforts to remove the drug from the body should not be delayed. Copious gastric lavage and/or induction of emesis may be indicated. Activated charcoal is probably ineffective unless administered almost immediately after acetaminophen ingestion. Neither forced diuresis nor hemodialysis appears to be effective in removing acetaminophen. Since acetaminophen in overdose may have an antidiuretic effect and may produce renal damage, administration of fluids should be carefully monitored to avoid overload. It has been reported that mercaptamine (cysteine) or other thiol compounds may protect against liver damage if given soon after overdosage (8-10 hours). N-acetylcysteine is under investigation as a less toxic alternative to mercaptamine, which may cause anorexia, nausea, vomiting, and drowsiness. Appropriate literature should be consulted for further information. (JAMA 237:2406-2407, 1977)

Clinical and laboratory evidence of hepatotoxicity may be delayed up to one week. Acetaminophen plasma levels and half-life may be useful in assessing the likelihood of hepatotoxicity. Serial hepatic enzyme determinations are also recommended.

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Family physicians have major tasks ahead

By George A. Dean, MD Southfield

The following article is excerpted from a recent talk delivered to Michigan family practice residents at their annual Scientific Day at the Hyatt Regency Dearborn.

It no longer is sufficient for family practitioners to say they provide quality care of the highest order; that our availability, accountability, and accessibility are superior; that our practice environment provides a better opportunity for promoting preventative health care; that family practice is efficient and beneficial for the patient, challenging and rewarding for the physician.

We now have to begin an extensive research program to validate these suppositions. The development of a vigorous research program in family practice is absolutely essential to the future of our specialty, and the quality of its teaching and patient care functions. The family physician in the 1980s should address himself to the definition of research goals, and the development of present methods applicable to family practice.

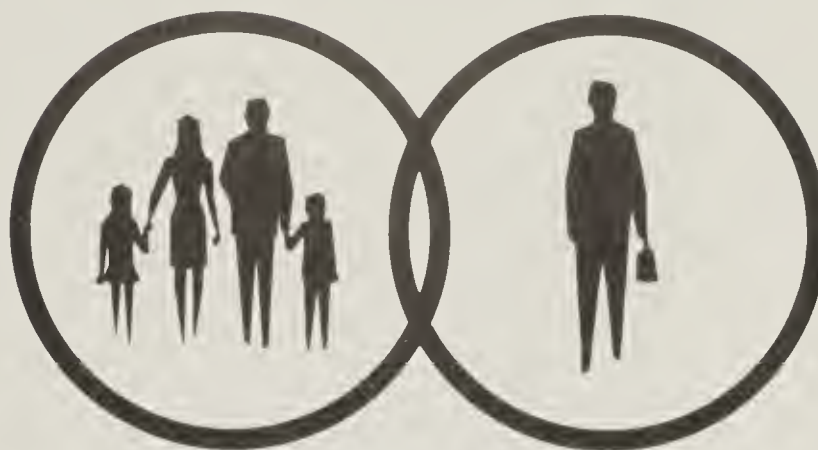
Major challenges

There are a number of additional charges to family practice in the coming decade. Here are some of them:

1. One of our goals is for 25 percent of graduating medical students to enter family practice. There are now more than 16,000 medical students in graduating classes in the United States, which means that in order to reach our goal, we must be able to accommodate 4,000 students with 4,000 first year residency slots in family practice.

We now have only 2,500 first year slots. We therefore must expand our present program and increase the number of existing programs by 1,500. This is a difficult task, but it is not unsurmountable. As we increase the numbers of training programs, we must carefully guard the quality of

(continued on page 380)



51 percent of residents now in primary care

A quiet revolution has taken place in the world of medicine.

"Primary care" specialties — the front line of medical care — are attracting growing numbers of physicians into their ranks.

Today, of the 375,000 active physicians, more than 182,000 practice "primary care" medicine. This is an increase of 29.7 percent since 1963, and it is a reversal of a trend which began after World War II. The percentage of physicians who classified themselves as providing "primary care" medicine declined to a low point of 30 percent in 1974.

The 1979-80 Directory of Residency Training Programs recently published by the American Medical Association shows that 51 percent of

the 64,332 young physicians enrolled in residency training programs in the U.S. (32,839) are in "primary care" programs.

And, of the 23,176 positions to be filled for the 1980-81 academic year, 12,221 (53 percent) will be in "primary care" fields — family practice, internal medicine, obstetrics/gynecology, and pediatrics.

Concern that an insufficient number of physicians would be available in the future to meet the medical care requirements of the public was strongly addressed in the late 1950s. At the time, the physicians to population ratio was 129 physicians per 100,000 population, including some 14,100 osteopaths. By the end of 1978, the ratio was 194

Growth of family practice in the U.S.

1970	1980
10 family practice residency programs	374 family practice residency programs
100 MDs in FP residencies	6,500 MDs in FP residencies
Five FP departments in U.S. universities	95 percent of universities have FP residencies
AAFP membership — 31,000	AAFP membership — 48,000

VIEWS/continued

these programs, and never forsake quality for quantity.

2. Hospital privileges for family physicians, commensurate with their training, experience, and proven ability, are necessary prerequisites for a satisfactory practice.

Young family physicians trained in residency programs can protect their interests by documenting procedures they have mastered in the training program, so that they can perform them in the hospitals where they gain privileges.

The large majority of hospitals continue to have open staffs. The majority of family physicians are satisfied with their hospital privileges.

However, clinical departments within the hospital will play an active role in protecting the rights of family physicians. In liaison with other specialty departments of the hospital, they will designate the privileges for family physicians. These family practice departments should monitor the quality of care

and the physician's performance.

That is why it is so important that every hospital in the United States have a clinical department of family practice, with its own credentials committee, its own audit committee, and its own executive committee.

3. To date, the Joint Commission on Accreditation of Hospitals has thwarted the AAFP's efforts to gain a position on its board of directors. This is an ominous sign regarding the rights and privileges of family physicians in hospital practice over the next decade.

The problem is further compounded by the fact that this year, the American Dental Association was granted full representation on the board, despite the fact that the admission of patients to the hospital under the care of dentists is miniscule when compared to the number of patients admitted by family physicians.

The American Academy of Family Physicians is vigorously and diligently dealing with this problem.

4. Equal reimbursement for equal service is another problem that challenges family practice in the eighties. The majority of states have reimbursement mechanisms which pay the family physician a lower fee for similar services.

The Michigan Academy of Family Physicians, with the assistance of the American Academy, has been the leader to rectify this inequity with a legal action in southeast Michigan which will be heard in the next several months. HEW and Blue Cross, the fiscal agent of the federal government are the objects of this action.

5. On the threshold of the eighties, the AAFP, as in the past, is now embarking on a far-reaching, innovative program in patient education. The International Ladies Garment Workers Union, and the AAFP have begun a cooperative program to educate our patients — ILGWU members — in health care.

If this venture is successful, additional ventures with other groups in our society should be tested. This will provide American business and American workers with authoritative, understandable and applicable health information, designed to enhance the general health and reduce health care costs.

6. The 1980s will see more females and minority group members entering the ranks of medicine. In the 1970s, seven percent of all physicians were females, and four percent of them were family physicians. In the 1980s, 13 percent of all physicians are females, and 25 percent of all medical students are females. Sixteen percent of the training residents in family practice are females.

7. Many of the family practice training programs operating today are still short of qualified faculty. The shortage is exacerbated by the need to further expand the capacity of these programs at both the undergraduate and graduate level. A faculty development effort is now under way and will hopefully alleviate the problem in the next several years.

NATIONAL STATISTICS/continued

physicians per 100,000 population, including 15,088 osteopaths.

The biggest increases in the past decade among "primary care" physicians has been in the areas of family practice, internal medicine and pediatrics. Since the first family residence program was approved in 1970, 21,611 physicians have entered family practice.

The average rate of growth for physicians practicing internal medicine from 1970 to 1978 was 4.2 percent and for pediatrics it was 3.6 percent. This was above the three percent annual rate of growth for all physicians.

The growth rate for surgeons in the same time period has been 1.7 percent.

There appears to be general agreement on the need to train more "primary care" physicians in the U.S. There appears to be some question however, on (1) the number of "primary care" physicians needed, and (2) the extent to which those providing secondary and tertiary care should be relied on to provide "primary care." Appropriate use of the increasing number of "physician extenders" should enable the "pri-

mary care" physician to provide services to more patients.

Although the number of students entering "primary care" residencies has increased substantially in the last few years, it is generally agreed, according to an AMA report entitled "Physician Manpower, Medical Education II," that more persons trained to deliver "primary care" are needed.

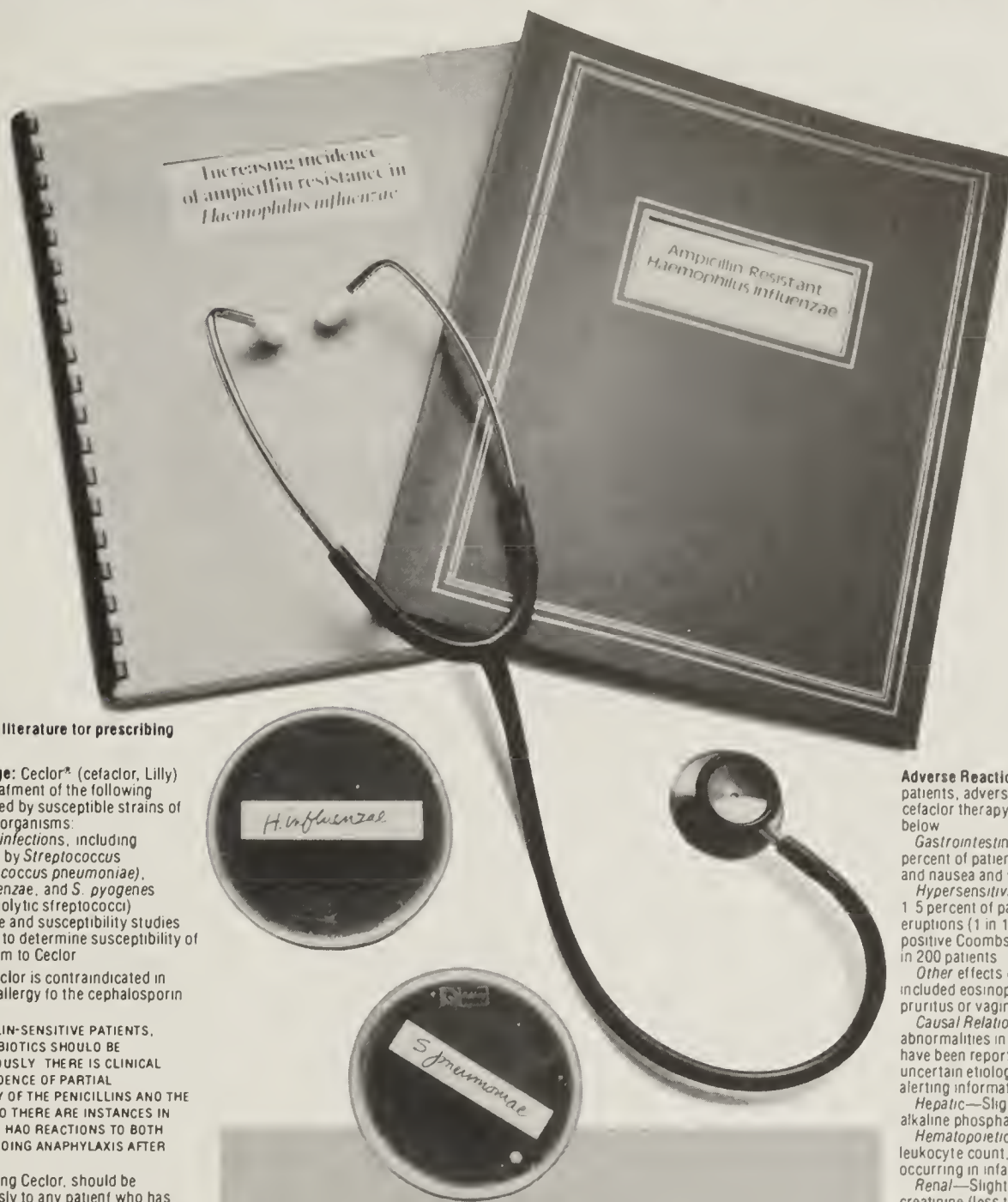
In 1973, the report explained, "the AMA accepted the fact that there existed the need for more 'primary care' physicians and adopted the goal to have 50 percent of all medical graduates enter residency training in the 'primary care' specialties in the coming years."

This goal has more than successfully been accomplished. Data released in 1977 showed that 65 percent of the medical school graduates began graduate medical education programs in the "primary care" specialties.

And none has been more successful than the family practice specialty whose growth went from essentially a zero base in 1969 to 325 accredited programs by mid-1977, according to the report.

Doctor Dean is past president of the Michigan Academy of Family Physicians.

An added complication... in the treatment of bacterial bronchitis*



Brief Summary. Consult the package literature for prescribing information.

Indications and Usage: Cefclor* (cefadlor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms:

Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae* (*Diplococcus pneumoniae*), *Haemophilus influenzae*, and *S. pyogenes* (group A beta-hemolytic streptococci). Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Cefclor.

Contraindication: Cefclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS, AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS TO BOTH DRUG CLASSES (INCLUDING ANAPHYLAXIS AFTER PARENTERAL USE).

Antibiotics, including Cefclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

Precautions: If an allergic reaction to cefadlor occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids.

Prolonged use of cefadlor may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs test may be due to the drug.

Cefclor should be administered with caution in the presence of markedly impaired renal function. Under such a condition, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

Usage in Pregnancy: Although no teratogenic or antifertility effects were seen in reproduction studies in mice and rats receiving up to 12 times the maximum human dose or in ferrets given three times the maximum human dose, the safety of this drug for use in human pregnancy has not been established. The benefits of the drug in pregnant women should be weighed against a possible risk to the fetus.

Usage in Infancy: Safety of this product for use in infants less than one month of age has not been established.

Some ampicillin-resistant strains of *Haemophilus influenzae*—a recognized complication of bacterial bronchitis*—are sensitive to treatment with Cefclor.¹⁻⁶

In clinical trials, patients with bacterial bronchitis due to susceptible strains of *Streptococcus pneumoniae*, *H. influenzae*, *S. pyogenes* (group A beta-hemolytic streptococci), or multiple organisms achieved a satisfactory clinical response with Cefclor.⁷

Cefclor®

cefadlor

Pulvules*, 250 and 500 mg

Adverse Reactions: In clinical studies in 1493 patients, adverse effects considered related to cefadlor therapy were uncommon and are listed below.

Gastrointestinal symptoms occurred in about 2.5 percent of patients and included diarrhea (1 in 70) and nausea and vomiting (1 in 90).

Hypersensitivity reactions were reported in about 1.5 percent of patients and included morbilliform eruptions (1 in 100), Pruritus, urticaria, and positive Coombs tests each occurred in less than 1 in 200 patients.

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

Causal Relationship Uncertain—Transitory abnormalities in clinical laboratory tests results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician.

Hepatic—Slight elevations in SGOT, SGPT, or alkaline phosphatase values (1 in 40).

Hematopoietic—Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40).

Renal—Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200).

[070379#]

* Many authorities attribute acute infectious exacerbation of chronic bronchitis to either *S. pneumoniae* or *H. influenzae*.

Note: Cefclor* (cefadlor) is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

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Additional information available to the profession on request from Eli Lilly and Company, Indianapolis, Indiana 46285. Eli Lilly Industries, Inc., Carolina, Puerto Rico 00630.

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MSMS 'Doctor of the Week' encounters pleasant surprises

By John Valantiejus, MD, Harbert

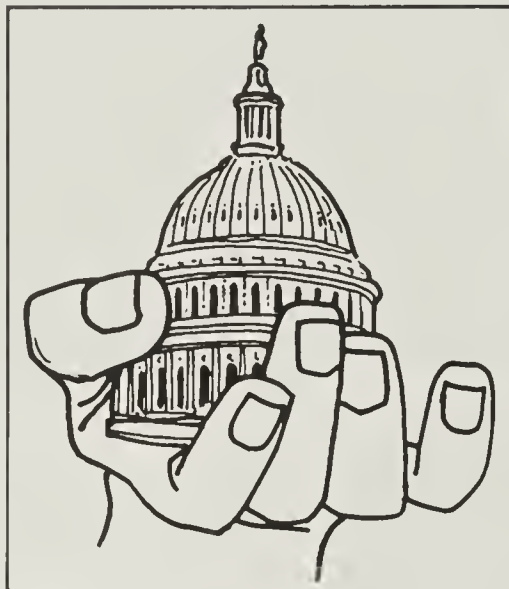
"It has been said if you like baloney and if you respect the law you shouldn't watch either of these being made." Too many varied things go into the hoppers before the final product is ground out in each case. This I can confirm after my two days' visit with our legislators in Lansing as "Physician of the Week."

MSMS staff convinced me that MDs should demonstrate their concern and involvement in the legislative process and I therefore volunteered for this program. Participation was no hardship or sacrifice. In matter of fact, quite to the contrary, it was very pleasant and self indulgent. The accommodations were graciously arranged by the folks of MSMS at the best hotel in Lansing and within walking distance of the Capitol. One legislator had described it as the best hotel in Lansing and another quoted "Where all the Democrats and prostitutes stayed." Most meals were taken at the City Club hobnobbing with all our legislators, and this was excellent.

Most hospitable

Our local legislators, Senator Harry Cast and Representative Carl Gnodtke, were most hospitable, and put me at ease and explained procedures. After having spent several hours observing their "modus operandi" and collecting snatches of their philosophy of life, I came away from Lansing feeling proud of the fine job these two men are doing. They have assumed their duties very well — their legislative policies are wisely chosen and they have learned how to get about in the maze of the State's capitol.

Doctor Valantiejus is president-elect of the Berrien County Medical Society.



A luncheon with Jackie Vaughn, Detroit senator, who was a Fulbright scholar and an Oxford University graduate, was an interesting sidelight of my stay in Lansing. We shared stories on our travels in the Soviet Union and our mutual admiration of U.S. Representative Phil Crane (IL.) who was a classmate of Senator Vaughn.

These stories we shared with a young female student who was in Lansing to lobby for lowering the legal age for alcohol consumption in the state. Naturally, since I am from New Buffalo where many, many problems were encountered when the age had been dropped to 18, I had some strong opinions to pass on to her on this subject.

Some legislation

Some of the legislation under consideration during my stay in the capitol included:

1 — The building of a subway in Detroit which would require untold millions of dollars from Michigan taxpayers.

2 — Increasing consumer control of Blue Cross and Blue Shield and reducing provider influence which I

was told was a compromise with even more undesirable rate setting controls by Insurance Commissioners.

3 — Allowing EMT's and ambulance drivers to be appointed deputy medical examiners.

I had some input on each of these subjects with our legislators as well as on many other matters to be considered.

One point of contention concerned the philosophy of the freedom we have in United States with respect to being able to decide to whom we will give; that is, the recipients of our charities.

This subject came up because one of our legislative considerations was to have private schools make separate financial accounting for the money they receive from private dollars. This money having brought a tax break to the donor was thought to be a gift of "State Funds" to the recipient and therefore some legislators believed the recipient was obliged to give an accounting of his use of such funds to the State.

This sort of thinking squeezed on my adrenals, but even more so did the discussion with Representative Bela Kennedy of the chiropractics and Laetrile. I understand, however, that despite his strong and unique opinions on these subjects, that our minority vice chairman on the Public Health Committee has been very fair on his legislation.

Capitol spectacular

The Capitol building itself is spectacular with enormous chambers, very sophisticated electronic equipment, magnificent chandeliers, marble pillars and illuminated or lavishly carpeted floors. I was surprised to learn that several years ago our legislature had considered tearing all this down and starting anew. Another pleasant surprise occurred when the security officer invited me to park in a space at the door of the capitol reserved for "Physician of the Week."

I can recommend volunteering for this program and to confirm this recommendation can tell you that the directors of this program have been seeking new volunteers since there have been too many doctors returning for second and third visits to our State Capitol.

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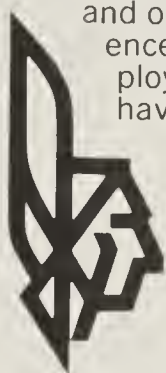
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Pick a plant — any plant — Doctor Churchill probably has it

By Nancy Nowak, special to Michigan Medicine



Doctor Churchill with a plant specimen at MSU's Beal-Darlington Herbarium.

John Alvord Churchill, MD, first fell in love with the natural world when he was four years old.

The love affair grew, along with a passionate interest in medicine. The Birmingham physician quite naturally adopted a marriage of medicine and botany as a way of life.

Today Doctor Churchill is professor of neurology and chief of the Child Neurology Division at Wayne State University — and the largest individual contributor to the Beal-Darlington Herbarium at Michigan State University.

Thousands of specimens

Recently honored by the Red Cedar Chapter of the Michigan Botanical Club, Doctor Churchill's specimens number between 15,000 and 20,000 — examples of 60 percent of the plants growing in the United States.

The co-evolving interests began with Doctor Churchill's boyhood camping excursions and a prolonged

hospital stay in early childhood.

Born in Boston, he was raised in Pittsburgh, where his father practiced law. Young Churchill spent half of each year roaming the lush countryside of Wexford Township, some 30 miles from the city.

Most people have a curiosity about the natural world, but our society discourages that curiosity, Doctor Churchill believes. He cites his early meanderings as representing 'real freedom' and recalls bringing home plants and toadstools and once refrigerating a 'gift' owl he had skinned.

"Talk about parental forbearance!"

His interest in medicine resulted from an infected knee requiring surgery and a lengthy confinement when he was six years old — an ordeal that left him thrilled with the idea of making sick people better.

His father arranged a part-time job at the Carnegie Museum in Pittsburgh, as a remedy for 'inattentiveness' in grade school. The young en-

thusiast spent all his spare time at work — until he went away to college.

His mentor at the museum was a burly, tattooed taxidermist, a 'real guy' who let him skin animals and ask questions by the hour.

"From time to time he'd tire of this and kick me out to work someplace else. I worked in paleontology chipping fossils, with birds and insects — and ended up in botany as I grew older."

When it came to a career choice, however, Churchill's father pointed out the economic advantages of medicine over botany and Churchill enrolled at Trinity College in Hartford, PA. He later interned at the University of Pennsylvania in Philadelphia where he completed his training in general and child neurology.

Interferes with profession

Doctor Churchill admits it's been a problem "putting it together right."

"All along, my profession has interfered with my avocation."

He 'piggybacks' his time, attending meetings across the country, heading for the hills of the region in his free time (he usually has a contact — a professor or botanist in the area).

"I collect during the summer as much as I can and then in the winter after work I relax by keying (identifying) plants in my home lab."

In the spring, Doctor Churchill brings these specimens to MSU and may send shipments to other universities on an exchange basis. Up to this point he has confined himself within the US borders, but he dreams of undertaking an expedition to Mexico. Mexico and Central America, the physician-botanist believes, are more closely tied to our destiny than other, distant places.

Extensively published in medical journals, Doctor Churchill is a research associate with the Smithsonian Institution's Department of Botany; has served on national committees, including the President's Council on Children & Youth (1970), as consultant for the National Institute of Neurological Diseases and Stroke (NINDB-1959-1967), and has been a member of the Committee for Rare and Endangered Species since 1974.

'There's a lot we physicians can do' to thwart health care intrusions — Doctor Annis

By Willah Weddon, special to Michigan Medicine

"In Washington, our representatives are gearing up with proposals, once the Democratic nomination has been decided, for cost containment of our hospitals, mandatory limitation of physicians' fees and national health insurance," Edward R. Annis, MD, told members of the MSMS House of Delegates during the annual meeting in Southfield.

He attributes these moves to the escalation in health costs, caused primarily by governmental actions over which the medical profession has no control.

Analyze costs

"If we're going to have legislative changes mandated in an effort to reduce costs, wouldn't it be wise to analyze what causes the high cost in the first place?" he asked rhetorically.

Doctor Annis, former AMA president from Florida, fought to stave off the Medicare program during his tenure in office. Today he heads the Mutual Association for Professional Services and schedules speeches to continue his battle against government interference in medicine.

He links rising health care costs to the growth of Medicare and Medicaid payments.

The escalation in health care costs since the beginning of Medicare in 1965 and Medicaid in 1966 is totally in keeping with, and parallels, the meteoric involvement of government financing, he said.

"Some 50 percent of the escalating health care costs can be shown to come from the inflation that affects all the rest of our country," he pointed out.

"This 50 percent we have no control over. It is the direct result of the fiscal and monetary policies of a liberal government that for 40 years has put increasing taxes on those who produce, to redistribute money to those that don't."

Government regulations contribute at least another 25 percent to the increase in health care costs, according to Doctor Annis.



Doctor Annis makes a point with Robert A. Rice, MD, left, chairman, Michigan delegation to the AMA, and MSMS Past President Vernon V. Bass, MD. (Photo by Willah Weddon)

Last year new regulations filled more than 70,000 pages in the Federal Register, he noted. Fulfilling these requirements cost \$39.88 per patient, per bed, per day in New York State, he said, quoting a study made by the New York State Hospital Association.

Included in the remaining 25 percent of increased costs are the swollen charges for liability insurance coverage, he said.

Another significant factor, he said, is the 10 percent of the population over 65 years of age who consumed 25 percent of the total health care dollar, according to a 1977 report by the Department of Health, Education and Welfare.

Physicians must educate

In three countries with socialized medicine — Britain, Finland and Sweden — the elderly are denied coronary bypass and hip replacement surgery because it is "uneconomical," he said. Those countries reason that the elderly and retired cannot be rehabilitated to the income-producing, tax-paying segment of the economy, he said.

"Imagine what would happen if the elderly knew what was in store for them if national health insurance programs, such as the Kennedy-

Waxman bill, were passed," he suggested.

People demand too much of health insurance, he continued.

Costs could be curtailed if people told their insurance companies they would take care of regular check-ups, cuts and bruises, but wanted insurance against the unpredictable and unusual.

They could also tell their union representatives not to demand first dollar coverage in health insurance in labor-management negotiations.

Physicians can explain to patients why health costs are high, why physicians have no control over these areas and tell them how they can help, Doctor Annis said. Patients vote and can write letters to elected officials.

"There's a lot we physicians can do, some things our patients can do, and a whole lot our elected representatives can do."

"But they'll only do it to the extent we're successful in educating our patients that these are things that must be done," the dynamic speaker emphasized.

"We've never had a better opportunity to forestall legislation mandating further intrusion in health care delivery."

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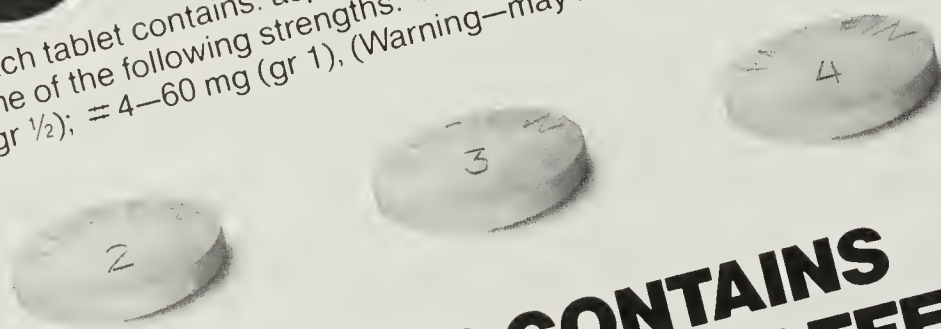
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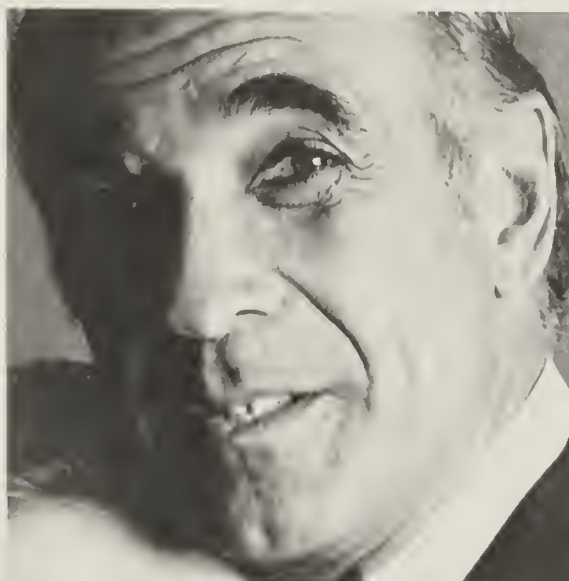
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continued on page 394

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MSMS, MSMS/A, AMA, and medical assistants

July 20-24 — AMA Annual Meeting, Chicago Marriott Hotel, contact: AMA, 535 N. Dearborn St., Chicago, 60610.

July 26-27 — Summer Seminar, State of Michigan Branch, American Association of Medical Assistants, Marquette, contact: Caroline Rich, MSMS headquarters.

Sept. 10 — MSMS Council, MSMS headquarters, contact: Warren Tryloff, MSMS headquarters.

Sept. 10-18 — MSMS/Intrav Swiss Adventure, contact: Marcelyn Ireland, MSMS headquarters.

Sept. 10-29 — MSMS/Intrav China Adventure, contact: Marcelyn Ireland, MSMS headquarters.

Sept. 11-12 — AMA 40th Annual Congress on Occupational Health, Salt Lake City, contact: Department

of Environmental Public and Occupational Health, AMA, 535 N. Dearborn, Chicago, 60610.

Sept. 27-29 — AMA meeting, "Drugs in Medical Practice," Crown Center Hotel, Kansas City, contact: Department of Scientific Assembly, AMA, 535 N. Dearborn St., Chicago, 60610.

Oct. 22 — MSMS Council, MSMS headquarters, contact: Warren Tryloff, MSMS headquarters.

Oct. 24-25 — AMA Fourth National Conference on Medical Care and Health Services in Correctional Institutions, Chicago, contact: AMA Correctional Programs, 535 N. Dearborn, Chicago, 60610.

Oct. 29-Nov. 1 — AMA Fourth National Conference on the Impaired Physician, Baltimore, MD, contact: Department of Mental Health, AMA, 535 N. Dearborn, Chicago, 60610.

Nov. 18-20 — MSMS Annual Scientific Meeting, Hyatt Regency Dearborn, contact: Sherry Fent, MSMS headquarters.

Dec. 3 — MSMS Council, MSMS

headquarters, contact: Warren Tryloff, MSMS headquarters.

Other meetings

July 16 — Board Meeting, Michigan Chapter, American College of Emergency Physicians, MSMS headquarters, contact: Michigan Chapter ACEP, P.O. Box 1611, East Lansing 48823.

Aug. 22-24 — 21st Congress of the Professions, Boyne Highlands, contact: Michigan Association of the Professions, 1407 S. Harrison Rd., P.O. Box 946, East Lansing, 48823, 517 337-1725.

Sept. 3 — Board Meeting, Michigan Chapter, American College of Emergency Physicians, MSMS headquarters, contact: Michigan Chapter ACEP, P.O. Box 1611, East Lansing 48823, 517/332-6500.

Sept. 25-27 — 1980 Walter P. Work Society, Stanford Court Hotel, San Francisco, contact: Nels R. Olson MD, Box 61, University Hospital Ann Arbor, 48109.

Oct. 25-30 — Annual Meeting

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American Academy of Pediatrics, Detroit, contact: Robert S. Holm, MD, Southwestern Michigan Area Health Education Center, 252 E. Lovell St., Kalamazoo, 49007, 616/383-6360.

Nov. 5 — Board Meeting, Michigan Chapter, American College of Emergency Physicians, MSMS headquarters, contact: Michigan Chapter ACEP, P.O. Box 1611, East Lansing, 48823.



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Each listing below, of programs that carry at least 3 hours of Category I credit, indicates a contact person, so the physician can obtain details. Physicians with questions about accredited programs may phone MSMS Headquarters, 517/337-1351.

Date: July 11-14, **Internal Medicine Conference.** **Location:** Grand Hotel, Mackinac Island. **Sponsor:** U-M Office of Continuing Medical Education. **For:** All interested physicians. **Cost:** \$150. **Contact:** Towsley Center for CME, 313/764-2287. **Approved for:** 11 hours of Category I Credit.

Date: July 21-25, **American College of Physicians — MKSAP V Review Course.** **Location:** Education and Research Center, Henry Ford Hospital, Detroit. **Sponsor:** Henry Ford Hospital and American College of Physicians. **For:** All interested physicians. **Cost:** ACP members, FACP, Residents and Research Fellows, \$200; Nonmembers, \$300; ACP Associates \$100. **Contact:** Medical Education, Henry Ford Hospital, 2799 W. Grand Blvd., Detroit, 48202, 313/876-1464. **Approved for:** 30 hours of Category I Credit.

Date: July 24-25, **Coller Penberthy Thirlby Medical Conference.** **Location:** Park Place Motor Inn, Traverse City. **Sponsor:** Munson Medical Center. **For:** All interested physicians. **Cost:** \$45. **Contact:** Norma Powers, Munson Medical Center, Traverse City, 49684. **Approved for:** 9 hours of Category I Credit.

Date: July 25, **Recent Advances in Pacemaker Technology.** **Location:** Towsley Center, Ann Arbor. **Sponsor:** U-M Office of Continuing Medical Education. **For:** All interested physicians. **Cost:** \$50. **Contact:** Towsley Center for CME, 313/764-2287. **Approved for:** 6½ hours of Category I Credit.

Date: July 25-27, 1980, **EKG Interpretation and Arrhythmia Management.** **Location:** Grand Hotel, Mackinac Island. **Sponsor:** International Medical Education Corporation. **For:** All interested physicians. **Cost:** \$215.00. **Contact:** International Medical Education Corporation, Division of Postgraduate Education, Dept. 12, 64 Inverness Drive East, Englewood, CO 80112

(800) 525-8646 Toll Free or (313) 773-1144. **Approved for:** 15 hours of Category I Credit.

Date: July 26, **Symposia on Teaching Skills.** **Location:** Holiday Inn, Traverse City. **Sponsor:** American Academy of Family Physicians. **For:** All members of the AAFP. **Contact:** Michigan Academy of Family Physicians, 416 N. Homer, Suite 107, Lansing. **Approved for:** 4 hours of Category I Credit.

Date: July 28-30, **Michigan Academy of Family Physicians 34th Annual Scientific Assembly.** **Location:** Holiday Inn, Traverse City. **Sponsor:** Michigan Academy of Family Physicians. **For:** Members of MAFP. **Contact:** Michigan Academy of Family Physicians, 416 N. Homer, Suite 107, Lansing 48912, 517/337-2065. **Approved for:** 15½ hours of Category I Credit.

Date: July 31-Aug. 3, **Michigan Ophthalmological Society Twelfth Annual Summer Conference.** **Location:** Grand Hotel, Mackinac Island. **Sponsor:** Michigan Ophthalmological Society. **For:** Ophthalmologists. **Cost:** \$75. **Contact:** Michigan Ophthalmological Society, 29927 W. 6 Mile Road, Livonia 48152. **Approved for:** 7 hours of Category I Credit.

Date: Aug. 22-25, **6th Annual Mackinac Island Conference.** **Location:** Grand Hotel, Mackinac Island. **Sponsor:** U-M Office of Continuing Medical Education. **For:** All interested physicians. **Cost:** \$150. **Contact:** Towsley Center for CME, 313/764-2287. **Approved for:** 11 hours of Category I Credit.

Date: Aug. 23-24, **Anatomy and Techniques of Regional Anesthesia.** **Location:** Wayne State University School of Medicine, Scott Hall, Detroit. **Sponsor:** Wayne State University. **For:** All interested physicians. **Contact:** Wayne State University School of Medicine, Division of Continuing Medical Education, 9B-32 Health Care

Institute, Detroit, 48201. **Approved for:** 12 hours of Category I Credit.

Date: Sept. 13, **The Practical Application of Electron Microscopy to Surgical Pathology.** **Location:** Munson Medical Center, Traverse City. **Sponsor:** Michigan Society of Pathologists. **For:** Pathologists. **Contact:** T. A. Reyman, MD, Department of Pathology, Mt. Carmel Mercy Hospital, Detroit, 48235. **Approved for:** 3 hours of Category I Credit.

Date: Sept. 17, **A Day On Cardiac Pacing.** **Location:** Michigan Inn, Southfield. **Sponsor:** Henry Ford Hospital. **For:** All interested physicians. **Cost:** \$40. **Contact:** Medical Education, Henry Ford Hospital, 2799 W. Grand Blvd., Detroit, 48202 313/876-1464. **Approved for:** 5 hours of Category I Credit.

Date: Sept. 24, **Renal Problems for the Practicing Physician.** **Location:** Kalamazoo Center, Kalamazoo. **Sponsor:** Michigan Nephrology Center. **Co-Sponsor:** Southwestern Michigan Area Health Education Center. **For:** All primary care physicians. **Cost:** \$40. **Contact:** Charles L. Zeller, Jr., MD, Continuing Medical Education, 252 East Lovell, Room 364, Kalamazoo, 49007. **Approved for:** 7 hours of Category I Credit.

Date: Sept. 24-25, 1980 **Western Michigan Trauma Symposium.** **Location:** East Auditorium, Butterworth Hospital, Grand Rapids. **Sponsor:** Greater Grand Rapids Area, American Association of Critical Care Nurses. **For:** All interested medical and paramedical personnel. **Cost:** \$15 per day. **Contact:** Beth DeVriendt, Butterworth Hospital, 100 Michigan St., NE, Grand Rapids, 49503 (616/774-1405). **Approved for:** 15 hours of Category I Credit.

Date: Sept. 25-26, **Nitrosoureas: Current Status and New Developments.** **Location:** Hyatt Regency Dearborn. **Sponsor:** Wayne State University School of Medicine Department of Oncology, Harper-Grace Hospitals and the Comprehensive Cancer Center of Metropolitan Detroit and Bristol Laboratories. **For:** All interested physicians. **Contact:** David Moss, Symposium Coordinator, Bristol Laboratories, P.O. Box 657, Syracuse, NY 13201. **Approved for:** 12 hours of Category I Credit.

Date: Sept. 25-27, **Electrophysiology of Cardiac Arrhythmias and Conduction Defects.** **Location:** Detroit Plaza Hotel. **Sponsor:** Michigan Heart Association and Council on Clinical Cardiology of the American Heart Association. **For:** All interested physicians. **Contact:** Eleanor D. Peterson, RN, Michigan Heart Association, P.O. Box LV 160, Southfield, 48076. 313/557-9500. **Approved for:** 16½ hours of Category I Credit.



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Date: Sept. 27, **What's New in the Chest.** **Location:** Education and Research Center, Henry Ford Hospital. **Sponsor:** Henry Ford Hospital. **For:** All interested physicians. **Contact:** Medical Education, Henry Ford Hospital, 2799 W. Grand Blvd., Detroit, 48202 313/876-1464. **Approved for:** 7 hours of Category I Credit.

Date: Oct. 2-5, **Michigan Chapter, American College of Physicians Regional Meeting.** **Location:** Sugar Loaf, Cedar. **Sponsor:** Michigan Chapter, American College of Physicians. **For:** Internists and family physicians. **Contact:** Boy Frame, MD, Henry Ford Hospital, 2799 W. Grand Blvd., Detroit, 48202. 313/876-2373. **Approved for:** 20 hours of Category I Credit.

Date: Oct. 3-5, **Diagnostic Ultrasound.** **Location:** Towsley Center, Ann Arbor. **Sponsor:** U-M Office of Continuing Medical Education. **For:** All interested physicians. **Cost:** \$175. **Contact:** Towsley Center for CME, 313/764-2287. **Approved for:** 16 hours of Category I Credit.

Date: Oct. 4-5, **Anesthesia, Obstetrics and the Newborn.** **Location:** Grand Traverse Hilton, Traverse City. **Sponsor:** Wayne State University School of Medicine and Michigan Society of Anesthesiologists. **For:** All interested physicians. **Cost:** \$75. **Contact:** Wayne State University School of Medicine, Division of CME, 9B-32 Health Care Institute, Detroit, 48201, (313) 577-1180. **Approved for:** 7 hours of Category I Credit.

Date: Oct. 4-5, **8th Annual Burns Clinic Medical Meeting.** **Location:** Holiday Inn, Petoskey. **Sponsor:** Burns Clinic Medical Center. **For:** All interested physicians. **Cost:** \$120. **Contact:** J. R. Postle, MD, Burns Clinic Medical Center, P.C., Petoskey, 49770, 616/347-7000, ext. 422. **Approved for:** 12 hours of Category I Credit.

Date: Oct. 8, **Selected Topics in Practical Cardiology.** **Location:** Education & Research Center,

Henry Ford Hospital. **Sponsor:** Henry Ford Hospital. **For:** All interested physicians. **Contact:** Medical Education, Henry Ford Hospital, 2799 W. Grand Blvd., Detroit, 48202 313/876-1464. **Approved for:** 7 hours of Category I Credit.

Date: Oct. 15, **Pediatrics Infections.** **Location:** Hurley Medical Center, Merliss Brown Auditorium. **Sponsor:** Hurley Medical Center. **For:** All interested physicians. **Contact:** Richard D. Garlick, Hurley Medical Center, Sixth Ave. and Begole, Flint, 48502 313/766-0142. **Approved for:** 6 hours Category I Credit.

Date: Oct. 16-18, **Implant Surgery for Joints and Tendons in the Hand.** **Location:** Blodgett Memorial Medical Center. **Sponsor:** American Society for Surgery of the Hand. **For:** All interested physicians. **Contact:** Alfred B. Swanson, MD, 290 Blodgett Professional Building, 1900 Wealthy Street, S.E., Grand Rapids, 49506. **Approved for:** 18½ hours of Category I Credit.

Date: Oct. 25, **Pulmonary Emergencies.** **Location:** Education and Research Center, Henry Ford Hospital. **Sponsor:** Henry Ford Hospital. **For:** All interested physicians. **Contact:** Medical Education, Henry Ford Hospital, 2799 W. Grand Blvd., Detroit 48202 313/876-1464. **Approved for:** 7 hours of Category I Credit.

Date: Nov. 8, **Symposium on Empathy and Countertransference.** **Location:** Hyatt Regency Dearborn. **Sponsor:** Michigan Psychoanalytic Society. **For:** Psychiatrists. **Contact:** The Michigan Psychoanalytical Society, 16310 West Twelve Mile Rd., Suite 204, Southfield, 48076. **Approved for:** 6 hours of Category I Credit.

Date: Nov. 17-18, **Treatment of Injuries of the Hand: Primary and Definitive Care.** **Location:** Detroit Plaza Hotel. **Sponsor:** Wayne State University School of Medicine, Department of Surgery and American Society for Surgery of

the Hand. **For:** All interested physicians. **Cost:** \$250. **Contact:** Gerald F. Prieur, Jr., MPA, Wayne State University School of Medicine, Continuing Medical Education, 9B-32 Health Care Institute, Detroit, 48202, 313/577-1180. **Approved for:** 19 hours of Category I Credit.

Date: Nov. 18-20, **MSMS Annual Scientific Meeting.** **Location:** Hyatt Regency Dearborn. **Sponsor:** Michigan State Medical Society. **For:** All interested physicians. **Contact:** Sherry Fent, MSMS, 517/337-1351. **Approved for:** 18 hours of Category I Credit.



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DEATHS

Charles L. Borden, MD Trenton

Charles L. Borden, MD, Trenton, died April 27 at the age of 79. Doctor Borden received his MD from the Case Western Reserve School of Medicine, Cleveland. In 1977, he received recognition from the American Academy of Family Physicians, Michigan Chapter and the Case Western Reserve University alumni for 50 years of service as a physician. Doctor Borden was a past president of the St. Clair County Medical Society.

Clarence J. Carpenter, MD Romulus

Clarence J. Carpenter, Romulus, died May 12. He was 86. Doctor Carpenter earned his MD from the University of Cincinnati Medical School. He founded the Wayne County Hospital, later known as Carpenter's Hospital and Clinic. When the hospital closed in 1960, Doctor Carpenter built a clinic on Second Street in Detroit. He was a member of the Industrial Medical Association and a past president of the Kiwanis Club in Wayne.

Alexander B. Gwinn, MD Hastings

Alexander B. Gwinn, MD, Hastings, died Apr. 12 at the age of 83. Doctor Gwinn was former health director in the Oceana-Newaygo-Lake counties area and director of the Comprehensive Health Clinic in Baldwin. He retired in 1978. He earned his MD from Detroit College of Medicine in 1930. Doctor Gwinn practiced in Hastings from 1936 to 1966.

Paul E. Mattman, MD Detroit

Paul E. Mattman, MD, Detroit, died May 4 at the age of 63. Doctor Mattman was a fellow of the American College of Physicians and a member of the Johns Hopkins Alumni Association. He earned his MD from Johns Hopkins in 1941. He had been in private practice in the David Whitney Building in downtown Detroit.

Carlin Mott, MD Detroit

Carlin Mott, MD, Detroit, died May 13 at the age of 87. Doctor Mott was head of the Wayne State University School of Medicine's biochemistry department from 1921 to 1963. In addition to maintaining a private practice, he also had been on the Providence Hospital staff. Doctor Mott earned his MD from Wayne State University School of Medicine in 1921.

William Roubeck, MD Southfield

William Roubeck, MD, Southfield, died May 18. He was 53. Doctor Roubeck was on the staffs of Sinai Hospital, Grace Northwest Hospital and Harper Grace Hospital in Detroit. He was on the Southfield Board of Health and was a member of the Oakland County Medical Society. He received his MD in 1955 from the Wayne State University School of Medicine.

Joseph N. Scher, MD Mt. Clemens

Joseph N. Scher, MD, Mt. Clemens, died Apr. 27 at the age of 78. Doctor Scher was a past president of the Macomb County Medical Society and had served as chief of staff at St. Joseph Hospital. In 1974, he was Mt. Clemens "man of the year." Doctor Scher received his MD in 1926 from the University of Toronto.

Marcus Sheffer, MD Liverpool, NY

Marcus Sheffer, MD, Liverpool, NY, died Apr. 21. He was 62. Doctor Sheffer earned his MD from Wayne State University School of Medicine. During his career, he was associated with Detroit Receiving Hospital and Ypsilanti State Hospital. His latest work was a private practice in Syracuse, NY.

Milton L. Sorock, MD Farmington Hills

Milton L. Sorock, MD, Farmington Hills, died Apr. 9. He was 69. Doctor Sorock received his MD in 1936 from the Wayne State University School of Medicine. During WWII, he commanded the U.S. Army's 37th Portable Surgical Hospital in the Pacific Theater. He was Sinai Hospital surgical chief from 1959 to 1970 and was a clinical assistant professor of surgery at Wayne State from 1963 to 1970. Doctor Sorock was a founder and past president of the Detroit Surgical Society.

Lloyd H. Spencer, MD Huntington Woods

Lloyd H. Spencer, MD, Huntington Woods, died Apr. 27 at the age of 80. In 1925, Doctor Spencer received his MD from the University of Western Ontario. After serving his internship at old Grace Hospital, he began a private practice in Royal Oak. Doctor Spencer retired from his practice in 1978.

Homer H. Stryker, MD Athens

Homer H. Stryker, MD, Athens, died May 5 at the age of 85. An inventor of orthopedic and surgical equipment used worldwide, Doctor Stryker developed the famed CircOlectric Bed, an electrically turned bed used to treat severely injured patients who cannot be turned by conventional means. In 1968, he was named to the President's Committee for Employment of the Handicapped. In 1972, Borgess Medical Center dedicated its rebuilt orthopedic department in Doctor Stryker's name. Doctor Stryker was active on MSMS committees and was past president of the Kalamazoo Academy of Medicine.

James M. Winkler, MD Ann Arbor

James M. Winkler, MD, Ann Arbor, died April 27. He was 53. Doctor Winkler was a surgeon on the staffs of St. Joseph Mercy Hospital and Beyer Hospital. He received his MD in 1955 from the University of Michigan Medical School. Doctor Winkler was a clinical assistant professor of surgery at the U-M, a diplomat of the American Board of Surgery and an officer of the Frederick A. Collier Surgical Society.

CLASSIFIED

The rate for each classified advertisement in *Michigan Medicine* is 15¢ per word, with a minimum charge of \$7.50. Copy for classified advertisements should be received not later than the first of the month preceding the month of publication.

Positions open

GP or Family Practice to join a 4 man group in West Central Iowa. Good community, and fairly new 100 bed hospital. Large practice opportunity here immediately, night and week end call shared equally. Guaranteed income, early partnership available. Call or write, Ed Murphy, Clinic Manager, Carroll Medical Center, 502 N. Court St., Carroll, Iowa 51401.

Director of Internal Medicine. Internal Medicine Residency Program Director sought for 481 bed community hospital in southeast Michigan, which is currently involved in a major expansion of its programs and facilities. The hospital's service area includes many affluent suburbs. In addition, it affords ample opportunity for cultural enrichment, both winter and summer recreation, and professional sporting events. St. Joseph Mercy Hospital, Pontiac, presently has 24 residents in internal medicine. Seeking Board Certified academic internist whose work would emphasize resident and medical student teaching; and supervision of patient care activities. Subspecialty training preferred. Excellent fringe benefits; salary negotiable. Contact Doctor Lawrence J. Zgliniec, Director of Medical Education, 900 Woodward Avenue, Pontiac, Michigan, 48053; or call (313) 858-3230.

Locum Tenens: Needed for established pediatric practice in beautiful Marquette, Michigan on Lake Superior in the Upper Peninsula. 50% office and 50% hospital pediatric practice with Level II NICU. Needed August 1980 to June 1981. Contact: Dale C. Alverson, MD, 1414 West Fair Avenue, Marquette, MI 49855. (906) 228-6704 or 228-9440 and page.

Physician Wanted for Jackson Med Center, Inc., a non-profit clinic. Position includes directing capable medical support staff, monitoring and providing patient care and planning for future expansion of present and future services provided. Ideal opportunity for aggressive physician interested in operating a "no risk" general practice. Internists and/or Family Practitioner preferable. Excellent salary (presently up to \$50,000) and fringe benefits. No investment required. Max. 40 hour work week. Resumes to: Jackson Med Center, Inc., 612 First Street, Jackson, MI 49203. Attention: E. Willoughby, MD.

OB-GYN: Board eligible or certified to join established mixed group including 2 ob-gyn spec. Ob practice directed toward family oriented childbirth concepts. Income and responsibility of existing Ob practice divided equally from first day of employment. Professional corp. with many fringe benefits. Excellent office and hospital facilities located in beautiful vacation area. Please send resume to: Robert J. Pranger, Bus. Adm., Medical Arts Group, P.C., 20 Cobb St., Cadillac, MI, 49601 or call (616) 775-6521.

Wanted — Full-time Staff Physician for 350-bed accredited hospital providing rehabilita-

tion, psychiatric and chronic disease services. General practice or internal medicine training and experience beneficial. Successful candidate must have Michigan license. Excellent salary and fringe benefits. Submit qualifications to: Personnel Director, Saginaw Community Hospital, 3340 Hospital Road, Saginaw, Michigan 48605.

Two Physicians Needed for Munising, Michigan. Rural community, gateway to Pictured Rocks National Park. Modern 40 bed hospital, ICU, computerized nuclear scanner, office space and hospital located next to Lake Superior. New school system, excellent summer and winter sports. Great place to raise a family. Three physicians already in the area, stable economic base. Contact Robert Hamilton, EVP, Munising Memorial Hospital, Sand Point Road, Munising, Michigan 49862.

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Positions With The State Of Michigan — Currently taking applications for positions expected to be available in the future. Primarily interested in board certified or board eligible internists with cardiology background. Office locations in Southfield, Lansing, and Traverse City. Also considering an office in Kalamazoo. Salary in 50's with approximately 40% fringe benefits. An equal opportunity employer. All enquiries treated confidentially. For further details please write: Disability Determination Service, P.O. Box 30011, Lansing, MI 48909, or call collect: Harry D. Nesmith, MD, Chief Medical Consultant (517) 373-7830. In Michigan, call toll free 1-800-292-2710.

Miscellaneous

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PRESIDENT'S PAGE

MSMS and its president — where are we going together?

By John R. Ylvisaker, MD, MSMS President

My first President's Page last month published my April address to the House of Delegates. My intent was to give each of our members an opportunity to be informed directly of:

My appraisal of the purpose of our Society's existence and the consonance of our current activities with that purpose;

My interpretation of the responsibility of the Society and its members to respond *internally* (with the Society structure) and *externally* (with our socio-political environment) to apply our purpose to current issues, and

My identification of three major issues which I have singled out that warrant a concentration of leadership effort:

- 1) the reimbursement system — a need for change.
- 2) Health planning — a need for aggressive involvement and for change.
- 3) Excessive regulation — a need for strong interaction and responsible counter action.

What does MSMS president do?

Without doubt, the presidency of the Society is honorary. It is certainly cherished as one of the highest honors conferred on a succession of selected members.

The presidency is necessarily symbolic and titular. It imposes a responsibility for statesmanship, for articulation of policies and positions of the Society, and for formal representation of the Society before the public.

In my view, the presidency

encompasses two other exceedingly challenging functions of a much more personal nature, each of which embodies a personal opportunity for the president.

They are **representation** of the interests and needs of the Society and of its members, and the exercise of the prerogative and responsibility of **leadership**.

The tenure of a president is so short that tasks can barely be started before these golden opportunities slip away. My efforts at representation had a headstart because of the teamwork established last year among the MSMS president, past-president, chairman of The Council, and president-elect.

Examples of my current activities in working with dedicated colleagues and staff:

- Developing long range goals for the Society.
- Developing and implementing a strong constructive relationship with the Michigan Hospital Association leadership.
- Working toward an effective advisory relationship with the Michigan Department of Public Health and with BCBSM.
- Continuing the development of a pooled pension trust for our members.
- Refining and implementing the new approach for assistance to impaired physicians.
- Responding to unique interests of individual members or small groups of members.
- Interacting in membership delinquencies.

For any of you who have

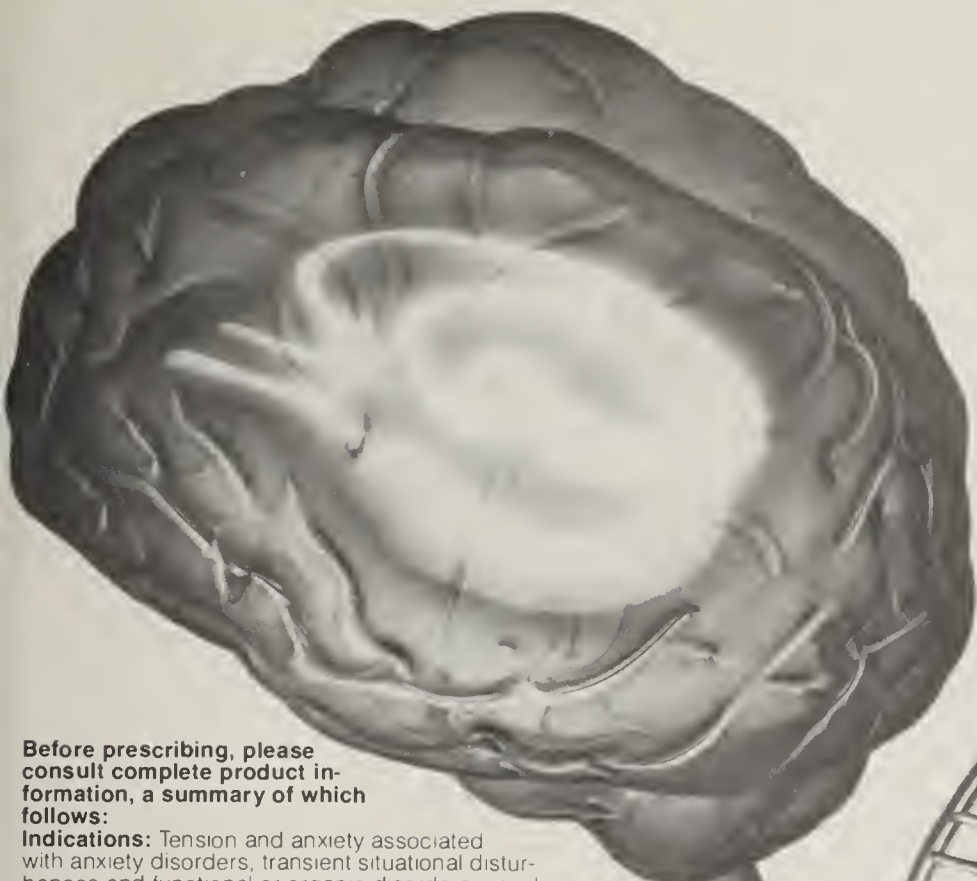
concerns where I might be of help, please call or write me personally.

Greatest challenge

The realm of leadership is where a president feels greatest challenge and apprehension. The principal thrust of my leadership efforts will be focused on the three issues already itemized.

Of these, the most crucial is the entire issue of reimbursement for provider services of health care. Particularly important is the impact of the present system on patterns of care and utilization, and on excessive expenditure. There needs to be developed an acute awareness of how our "no-responsibility" reimbursement system leads inevitably to regulatory excesses.

Our Society and its membership must be oriented to effecting change, not merely to living with the consequences of decisions made in the political arena. My subsequent President's Pages will discuss the issues and options as I see our opportunities for action.



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Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms similar to those with barbiturates and alcohol have been observed with abrupt discontinuation, usually limited to extended use and excessive doses. Infrequently, milder withdrawal symptoms have been reported following abrupt discontinuation of benzodiazepines after continuous use, generally at higher therapeutic levels, for at least several months. After extended therapy, gradually taper dosage. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

Use in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed, drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

Dosage: Individualize for maximum beneficial effect. *Adults:* Tension, anxiety and psychoneurotic states, 2 to 10 mg b.i.d. to q.i.d., alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed, adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. *Geriatric or debilitated patients:* 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) *Children:* 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

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for the prescribing
and appropriate use of
minor tranquilizers

- Individualize dosage for maximal beneficial effect.
- Prescribe the specific quantity needed until the next checkup period, schedule frequent, periodic reexaminations to monitor results of therapy.
- Establish treatment goals and gradually discontinue medication when these have been met.
- Avoid prescribing for individuals who appear dependency-prone or whose histories indicate the potential for misuse of psychoactive substances, including alcohol.
- Caution patients against engaging in hazardous occupations requiring complete mental alertness such as operating machinery or driving.
- Advise patients against the ingestion of alcoholic beverages while undergoing therapy with minor tranquilizers.
- Counsel patients to follow label directions, keep medication out of children's reach, and dispose of unused or old medication.
- Caution patients against giving medication to others.
- Avoid abrupt cessation of extended therapy by tapering dosage before discontinuing medication.



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AUG 19 1980

MICHIGAN MEDICINE

Vol. 79, No. 21
July 28, 1980

Breaking News for Michigan Doctors

MEDIGRAM

CAPSULES

ROBERT E. RICE, MD, Greenville, beloved and respected MSMS leader and chairman of the Michigan delegation to the AMA, died unexpectedly Wednesday, July 16, at the age of 60. MSMS members, officers and staff are mourning the loss of the family physician who has been an MSMS council member, served on the Finance, Socio-economics and Rural Health committees and was on the board of directors of the Michigan Physicians Mutual Liability Company. Doctor Rice also was active with the Michigan Health Council and with the Michigan Academy of Family Physicians. A full obituary will appear in the September issue of Michigan Medicine.

OVER 50 MSMS members responded in the first week to the July 11 Medigram request for volunteers to care for Indochinese refugees resettling in Michigan. A list of volunteers is being compiled by the MSMS Task Force on Indochinese Refugees for referral through county medical societies and MSMS. Interested physicians who would like to volunteer for initial care of the refugees may submit their name, address, and specialty to Sherry Fent at MSMS headquarters. The July issue of Michigan Medicine has cover and special report inside devoted to the first in a series of articles on the statistics, medical and cultural status of the refugees.

MSMS Council highlights

At its July 11-12 Midsummer meeting at the Marquette Holiday Inn, the MSMS Council:

- 1) Supported in concept a new plan for emergency medical services categorization. The new plan was proposed by the MSMS Ad Hoc Committee on EMS Categorization. It is designed to replace the current state categories, being more sensitive to emergency departments' best use.
- 2) Approved the proposal for regionalized perinatal care made by the MSMS Committee on Maternal and Perinatal Health and authorized the committee to develop recommendations for the implementation of the proposal, for The Council's consideration.
- 3) Approved additional consultation and lobbying resources to increase MSMS capacity in political concerns, including those of specialty societies and other physician subgroups; and also approved increased MSMS staffing for legislative research and analysis.
- 4) Okayed guidelines for operation of a MSMS financial assistance plan for impaired and disadvantaged physicians.
- 5) Okayed purchasing the MSMS master pension program from the MSMS Physicians Service Group, Inc., and authorized further activity to survey the market by seeking substantial commitments from physicians prior to implementing the plan.
- 6) Approved small fee increases for members and residents attending the MSMS Annual Scientific Meeting.
- 7) Approved a revised MSMS budget for fiscal year 1980.

Mark your calendar today!
1980 MSMS Annual Scientific Meeting
Nov. 18-19-20, Hyatt Regency Dearborn

THE WAYNE COUNTY MEDICAL SOCIETY has named Susan Adelman, MD, Southfield, and Sidney D. Kobernick, MD, Detroit, editor and co-editor, respectively, of the Detroit Medical News. Doctor Adelman succeeds Kenneth J. Ray, MD, as editor. Doctor Ray was installed in June as WCMS president.

THE MICHIGAN HEALTH COUNCIL is the recipient of a \$314,500 grant from the Kellogg Foundation to stimulate development, cooperation and involvement among the MHC's 150 member organizations. MSMS is one of them. The Health Council plans a wide range of activities to emphasize the importance of making behavior and environmental changes conducive to good health. The Health Council in its comprehensive health promotion commitment plans specific attention on the elderly, rural residents and school-age youngsters.

THE FULL TEXT of "Medicine, Government and Common Sense," the well-received talk by AMA Past President Edward R. Annis, MD, Miami, at the 1980 MSMS House of Delegates annual session, is available from Richard Campau at MSMS headquarters.

MDSS recommends enforcing limit on Medicaid pre-op stays

On July 9, the Michigan Department of Social Services recommended to the Legislature that Medicaid pre-admission and early testing cost control programs be "implemented and enforced" limiting covered pre-operative stays to two days for elective surgery. The limitation on Medicaid benefits was recommended despite MDSS observations that 82.3 percent of all surgeries (emergency, elective and medical admissions becoming surgical) had pre-operative stays of two days or less; 75.4 percent were one day or less, including 21.6 percent with zero pre-operative days. Rationale for the new policy is that it creates an incentive to adopt pre-admission testing programs for elective surgeries so that pre-operative stays over two days will be minimized. MSMS, the Michigan Hospital Association and PSROs consistently have urged MDSS to recommend continuing the voluntary approach to pre-admission testing along with cooperative arrangements among the state agency and PSROs to seek corrective actions in those hospitals where pre-operative stays are excessive.

Public hearings ahead on CON

The Michigan Department of Public Health will hold a public hearing on proposed rules relative to certificates of need on Friday, Aug. 15, at 10 a.m. in the Manty Conference Room, MDPH, 3500 N. Logan Street in Lansing. Of particular interest to physicians is Rule 106 which, for the first time, would define organized ambulatory health care facilities, as distinguished from private practice offices, and make the facilities subject to CON requirements. Although professional service corporations are exempt, the list of criteria the department shall consider in differentiating the two is extensive. Physicians can obtain a copy of the proposed rules from Sherry Wellman at MSMS headquarters.

Michigan State Medical Society
120 West Saginaw Street
East Lansing, Michigan 48823

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Editor: Judith Marr

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SEP 3 1980

Breaking News for Michigan Doctors

MICHIGAN
MEDICINE

Vol. 79, No. 22
August 8, 1980

MEDIGRAM

CAPSULES

PRESIDENT JOHN R. YLVISAKER, MD, will testify on behalf of MSMS at the Aug. 15 public hearing on certificate of need rules proposed by the Department of Public Health. Since the rules were announced, MSMS officers, legal counsel and staff have worked hard to analyze the proposed language in relation to the MSMS House of Delegates directive to prevent extension of CON to physicians' private offices. MSMS will offer recommendations to more clearly differentiate between an organized ambulatory health care facility, which is subject to CON, and a private practice office, which is not.

THE LEGISLATURE'S SPECIAL COMMITTEE on Bed Reduction will meet again Aug. 27 to try for a position on remodeling the proposed southeast Michigan bed reduction plan. Special Committee members could not agree on their staff members' proposals at an earlier session July 23, objecting to staff's "kid glove" approach to the proposed bed reduction plan of the Comprehensive Health Planning Council of Southeast Michigan. CHPC-SEM is the health systems agency responsible in that geographic area for developing a bed reduction plan.

AMA revises ethics code

Ending years of debate, the AMA House of Delegates in annual session July 20-24 in Chicago revised its Principles of Medical Ethics.

The new code was prepared by an ad hoc committee after two years of study and consultation with component medical societies and individuals. It is designed to be the "foundation upon which the opinions and reports of the Judicial Council will be based, establishes broad areas of responsibility for all physicians and emphasizes the belief that ethical standards are developed for the benefit of the patient," says the committee.

The text of the new ethics code will be published in the Aug. 1-8 issue of American Medical News.

Donald N. Sweeny, Jr., MD, Detroit, senior member, Michigan delegation to the AMA House, chaired the House's Reference Committee on Changes in the Constitution and Bylaws, which dealt with the prodigious task of reviewing and recommending on the new code. The Michigan delegation was faced with the loss of its chairman, Robert E. Rice, MD, Greenville, who died two days before the delegation convened in Chicago. Michigan physicians were led by Vice Chairman Richard J. McMurray, MD, Flint, who late in the week, was elected to the chair; Frank B. Walker, MD, Grosse Pointe, becoming vice chairman; and Robert D. Burton, MD, Grand Rapids, continuing as secretary/treasurer. Donald K. Crandall, MD, Muskegon, was appointed the AMA delegation representative on the MSMS Council.

In addition to the MSMS-elected delegation in Chicago, there were 10 Michigan doctors representing specialty societies. And the AMA Board of Trustees renamed John J. Coury, MD, Port Huron, to its executive committee.

In other actions, the AMA House adopted a report declaring it unethical for physicians to participate in capital executions. The House also called on physicians to become better informed about HMOs if interest is present in their own community, but referred back to the Board a recommendation that HMOs be recognized as one form of health care delivery which may result in lower total cost for enrollees.

Clear Oct. 30 for MSMS Public Affairs Leadership Conference

MSMS members may plan now to attend the MSMS Public Affairs Leadership Conference Oct. 30, at Long's Convention Center, Lansing. Just six days before the Nov. 4 elections, MSMS is presenting this program addressing the political and socio-economic issues facing medicine today.

Richard Scammon, director, Election and Research Center, Washington, DC--"A tremendous speaker," according to Thomas C. Payne, MD, MDPAC chairman, Lansing--will start the day off with a colorful discussion entitled, "America at the Polls."

Sen. Carl Levin has been invited to be keynote speaker, and the program will close with Edward R. Annis, MD, former AMA President, who was well received by MSMS delegates in May. Other topics will include the FTC, Medicaid, Blue Cross Blue Shield reform, HMOs-IPAs, professional liability and MSMS internal operations. Please watch for registration materials in coming issues of Medigram and Michigan Medicine. Kevin Kelly, MSMS headquarters, has details. It will be a day well spent!

Conference committee to work on HB 4555

The conference committee to work on differences between House and Senate versions of HB 4555 -- Blue Cross and Blue Shield Reform and cost containment -- was scheduled to begin work this month on more than 100 items at issue. In a rare move, the leadership named two ex officio members from each house in addition to the standing appointments of three members each from the Senate and House; thus the anticipated makeup of the conference committee is Sens. Arthur Miller (D-Warren), Edward Pierce (D-Ann Arbor) and Donald Bishop (R-Rochester) and Reps. Matthew McNeely (D-Detroit), David Hollister (D-Lansing) and Don Van Singel (R-Fremont). Ex officio will be Sens. Jack Faxon (D-Detroit) and Robert Young (R-Saginaw) and Reps. Mary Brown (D-Kalamazoo) and James Hadden (R-Adrian). Among the many issues MSMS will be watching are per case participation, direct payments to psychologists, makeup of the board of directors and the appeals mechanism in the cost containment program.

MSMS Annual Scientific Meeting just three months away

MSMS has the dates -- Nov. 18-19-20

the place -- Hyatt Regency Dearborn

the courses -- 54 Category I sessions

the speakers -- 250 state, national experts

the prices -- a low \$5 per credit hour
for members

It's up to you, Doctor, to take advantage of this superlative opportunity to learn, to earn a possible 18 Category I credit hours, to enjoy the company of your colleagues and the fine setting of the 1980 MSMS Annual Scientific Meeting. Registration forms will appear soon in this newsletter and in Michigan Medicine. Don't miss out.

Michigan State Medical Society
120 West Saginaw Street
East Lansing, Michigan 48823

MICHIGAN MEDICINE

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CAPSULES

SEP 8 1980

DON'T MISS the next Medigram!

That issue will contain all the details, and the registration form, for the 1980 MSMS Annual Scientific Meeting Nov. 18-19-20 at the Hyatt Regency Dearborn. You'll find course titles, times, descriptions, directors and speakers, plus information on specialty society meetings during the Annual Scientific Meeting. Course fees are a minimal \$5 per credit hour for members and \$5 per course for residents. The next Medigram is a must for your Annual Scientific Meeting planning!

ANOTHER MSMS MEMBERSHIP BENEFIT will be announced in October. MSMS members are urged to watch their mail for information about the newest MSMS member benefit--life insurance protection for spouses and children. A letter, the fact sheet and enrollment form will be mailed to every member Oct. 1.

MEDIGRAM

President Ylvisaker testifies against CON in MDs' offices

At a public hearing Aug. 15, MSMS made one of 20 formal statements against the Michigan Department of Public Health's proposed certificate of need rules. The hearing drew a large crowd, including MSMS President John R. Ylvisaker, MD, who testified on behalf of MSMS, and representatives of the Michigan Hospital Association, Greater Detroit Area Hospital Council, HSAs and individual physicians. Most of the testimony centered on proposed rule 106, which would differentiate between organized ambulatory health care facilities and private physicians' offices. Doctor Ylvisaker testified that the proposed rules fail to clearly distinguish between the two. He emphasized the AMA and MSMS positions that private physicians' offices should be exempt from CON requirements, and offered MSMS cooperation and assistance for "appropriate revision of the rules."

Five-year action plan goal of special MSMS meeting

An action plan for the next five years is the goal of the MSMS Committee on Long-Range Planning for its special meeting Sept. 17 at MSMS headquarters. Committee members will be aided by planning and management consultant Tom Martin of Kansas City, who has led similar groups for other state medical societies and the American Society of Association Executives. Committee members, chosen to represent all ages, specialties and geographic locations, will be joined by a few additional interested MSMS members, for best possible representation. Chairing the committee is MSMS President John R. Ylvisaker, MD, Pontiac. Also at the meeting will be Donald N. Sweeny, Jr., MD, Detroit, chairman and James J. Humes, MD, Detroit, vice chairman, Task Force on MSMS Structure.

In this issue . . .

is a program and the registration form for the stimulating 1980 MSMS Public Affairs Leadership Conference scheduled Oct. 30 at Long's Convention Center, Lansing. The conference, designed to increase the knowledge and awareness of MSMS leaders, is open to all members. Fill out the form and mail today!

ROBERT J. TOTEFF, MD, Saginaw, MSMS Councilor and active committee member, is the Michigan Academy of Family Physicians' "Family Physician of the Year." Doctor Toteff was named at the July 26-30 annual meeting of the MAFP.

THE MSMS/PHYSICIAN SERVICE GROUP, INC. continues to conduct practice management consultations. During the last year they have consulted with physicians in a variety of fields. All physicians consulted with have been pleased with the resulting efficiency and effectiveness of their office operations.

A practice management consultation covers a variety of office operations such as accounting, office set-up, filing systems, scheduling, work flow, patient flow and personnel. If you should need advice in these areas and others, contact John Anthony at 517/337-1351.

WITH THE NEW MODEL YEAR fast approaching, MSMS members may wish to investigate the possibilities of leasing an automobile through the special MSMS member service plan. The plan provides a special group rate, may reduce tax burdens, frees capital and is convenient and flexible, with varying lease terms and both closed-end and open-end lease types. MSMS members may select any make and model with the trim, upholstery, color and optional equipment desired. Contact Wayne Burmeister at MSMS headquarters for further details.

State's medical arbitration not affected by 'unconstitutional' ruling

A Wayne County Circuit Court judge's recent ruling that the Michigan medical arbitration law is unconstitutional does not affect the statewide arbitration system, says the Michigan Insurance Bureau. It is Judge Victor Baum's opinion that the medical arbitration portion of the Michigan Medical Malpractice Act violates due process of law. However, the Insurance Bureau, in an Aug. 7 letter to hospital administrator and personnel offering arbitration agreements, says, "Judge Baum's decision is only binding on the litigants in the particular case he was hearing. Only an appellate court could make a decision that would affect the program on a statewide basis. It is anticipated a decision concerning the constitutionality of medical arbitration will be made sometime in the future...In the meantime, hospitals should continue to offer an arbitration agreement to each patient as required by law."

The Insurance Bureau has released the following statistics on arbitration cases to date:

--216 medical malpractice cases filed in arbitration

--60 cases closed, as follows:

15 withdrawn

28 settled before arbitration, amounts ranging from \$363 to \$220,000 (Average settlement is \$19,620.)

15 decided by arbitration panels
(12 decided in favor of respondent, 3 for plaintiff)

2 dismissed

--13 months average from filing to resolution

--2.1 days average for arbitration hearing

--\$1,638 average cost of administering hearing

Delta, Schoolcraft societies chartered

The new Delta and Schoolcraft county medical societies officially received their charters at the midsummer meeting of the MSMS Council. Ali H. Sawaf, MD, Escanaba, accepted the new Delta CMS charter from MSMS Council Chairman Louis R. Zako, MD, while MSMS Councilor Busharat Ahmad, MD, Marquette, accepted for Schoolcraft. The two groups of physicians formerly were joined in the Delta-Schoolcraft County Medical Society.

Sign Up Now!



For telephone reservations:
Please contact Bill Madigan
or Kevin Kelly
at MSMS Headquarters —
517/337-1351.

The First Annual MSMS Public Affairs Leadership Conference is being held on Oct. 30 at Long's Convention Center, Lansing.

The 1980 MSMS House of Delegates enthusiastically challenged MSMS and the medical community to make an aggressive effort to prepare and inform physician leaders. Thus, this program will concentrate

on those professional, socio-economic, political and administrative trends, ideas and problems that are clearly and, in some cases, ominously, visible on the professional horizon for every practicing physician today.

This promises to be a day well spent in professional growth and fellowship!

The program

9:00 REGISTRATION

9:30 CALL TO ORDER — John R. Ylvisaker, MD, MSMS President

9:45 "AMERICA AT THE POLLS" — Richard Scammon, Director, Elections Research Center, Washington, DC

10:45 "POLITICAL ACTION — MDPAC" — Thomas C. Payne, MD, Chairman, Michigan Doctors Political Action Committee

11:00 "FEDERAL TRADE COMMISSION DEVELOPMENTS" — Louis R. Zako, MD, Chairman, Michigan State Medical Society Council

11:15 "ON THE STAND . . ." — A. Stewart Kerr, MSMS Legal Counsel, Kerr, Russell and Weber, Detroit

11:30 "REVIEW, PREVIEW AND PROGNOSTICATIONS FROM THE UNITED STATES SENATE" — Honorable Carl Levin, United States Senator

12:15 LUNCH — Luncheon Speaker, AMA Board of Trustees member to be named

1:30 "INTERNAL OPERATIONS AT MSMS HEADQUARTERS" — Thomas Berglund, MD, Vice-Chairman, MSMS Council

2:00 "MEDICAID DURING THE MICHIGAN RECESSION" — David Siegel, MD, Chairman, Medicaid Liaison Committee

2:20 "BLUE CROSS/BLUE SHIELD REFORM" — W. E. Maldonado, MD, Chairman, Committee on State Legislation and Regulations

2:40 "GROWTH IN HMO-IPA PREPAYMENT PLANS IN MICHIGAN" — Jay Harness, MD, Chairman, Advisors to the Bureau of Economics

3:00 "PROFESSIONAL LIABILITY INSURANCE IN MICHIGAN" — Robert M. Leitch, MD, President, Michigan Physicians Mutual Liability Corp.

3:20 "THE NATURE OF LEADERSHIP IN MEDICINE: There's a Lot We Physicians Can Do" — Ed Annis, MD, Former AMA President, Presently — Consultant, Mutual Association for Professional Services

Please return to:

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Michigan State Medical Society
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City _____

Name _____

City _____

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☐ Physician ☐ Other _____

Registration Fee: \$25 includes luncheon

Amount enclosed \$ _____

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CHANNEL 19 public television station, serving Saginaw-Bay City-Midland, is reactivating its popular "Ask the Doctor" call-in live physician panel show. For the second year, Edward S. Bernrueter, MD, Saginaw, will host the program, which is scheduled to begin broadcasting the first Thursday evening of each month starting Oct. 2. MSMS will help promote the program by providing a poster for all interested physicians' reception rooms.

THE 1981 MSMS HOUSE of Delegates meeting is scheduled May 1-2-3 at the Troy Hilton Inn. Please check with Richard Campau at MSMS headquarters for further details.

THE MSMS MEMBERSHIP Recruitment and Retention Committee will meet Sept. 24 to finish its proposal for a major MSMS membership promotion effort to begin in 1981. The committee plans to present its proposal to the MSMS Council at its Oct. 22 meeting.

Legislature to reconvene Sept. 3; BCBSM reform, budget key issues

The Michigan legislature returns Sept. 3 for its 1980 fall session. Key medical legislative business will pick up where it left off, with reports expected from the joint conference committee working on HB 4555, the bill to reform Blue Cross Blue Shield of Michigan. The conference committee had not begun to meet at the time of this writing. The state's shrinking budget is still at issue, also. With the beginning of the fiscal year looming Oct. 1, the House has taken no action on budget bills. MSMS legislative forces are expecting some fall action on HB 5401, establishing the position of medical examiner investigator; and SB 374, repealing the Public Health Code section which requires drug control licenses of physicians who routinely dispense from their offices.

Over 80 MDs respond to call for refugees' care here

Over 80 Michigan physicians have volunteered to aid Southeast Asian refugees here with initial health care. MSMS requested the names of physicians in earlier issues of Michigan Medicine and Medigram. MSMS now will send copies of the list to component societies so that referrals may be handled on the local level. MSMS also will handle referrals if the component society wishes. Further information is available from Sherry Fent and Dennis Paradis at MSMS headquarters.

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MICHIGAN MEDICINE

August 1980

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Vol. 79, No. 23

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Who to call at MSMS headquarters

Advertising (in <i>Michigan Medicine</i>)	Bonnie Groff
AMA Delegation	Bruce Ambrose, Wayne Burmeister
Annual Scientific Meeting	
Program	Sherry Fent
Meeting Arrangements	Marce Ireland
Arbitration	Bill Madigan
Auto Lease Plan	Wayne Burmeister
Blue Cross Blue Shield	John Richards
Board of Medicine	Kevin Kelly
Continuing Medical Education	
Accreditation	Marce Ireland
Category I Calendar (for <i>Michigan Medicine</i>)	Bonnie Groff
MSMS-Sponsored Conferences	Sherry Fent
Dues Payments	Jerry Trahan
Financial Operations	Dick Campau
Foreign Medical Graduates	Mert Scholten
Governmental Agencies Liaison	Sherry Wellman
Health Career Information	Mert Scholten
HMOs (Health Maintenance Organizations)	John Richards
HSA Support Center	Dennis Paradis
Impaired Physicians	Marcelyn Ireland
Jail Health Project	David Schut
Judicial Commission	Vada Davis
Legislation	Bruce Ambrose
Maternal Health Committee and Conference	Katie Brewbaker
Medicaid	Sherry Wellman
Medical Assistants	Caroline Rich
Medical Auxiliary	Caroline Rich
Medical Care Costs	John Richards
Medical Ethics	Vada Davis
Medigram	Judy Marr
Meeting Information (National, State)	Bonnie Groff
Member Services	Wayne Burmeister
Membership Records	Peg Berry
Michigan Association for Medical Education	Meredith Fors
Michigan Doctors Political Action Committee	Kevin Kelly
<i>Michigan Medicine</i> (MSMS Journal)	Judy Marr
Michigan Psychiatric Society	Helen Schulte
Michigan Society of Anesthesiologists	Meredith Fors
Michigan Society of General Surgeons	Caroline Rich
Michigan Society of Respiratory Therapists	Caroline Rich
MSMS Committee Meeting Schedule	Katie Brewbaker
MSMS House of Delegates	
Agenda and Schedule	Dick Campau
Meeting Arrangements	Marce Ireland
MSMS-Sponsored Insurance Programs (Life, Health, etc.)	Wayne Burmeister
MSMS Travel Programs	Marce Ireland
MSMS News Relations	Mert Scholten
Physician Hospital Relations	Dick Campau
Physician Legislative Network	Kevin Kelly
Physician Service Group	John Anthony
Practice Management Seminars	John Anthony
Professional Liability Insurance	Bill Madigan
PSRO	Sherry Wellman
Socio-Economic Surveys	John Richards
Specialty Societies	
Information	Katie Brewbaker
Council of Specialty Societies	Bill Madigan
Third Party Payors	John Richards

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East Lansing, MI 48823



MICHIGAN MEDICINE

August 1980, Volume 79, Number 23

Special report

- 408** Our annual *Michigan Medicine* report on legislation comprises the special report this month. The tortuous progress of HB 4555 is the lead story, with capsules on other medical bills included; W. E. Maldonado, MD; Bruce W. Ambrose; Sherry N. Wellman

In this issue, *Michigan Medicine* continues the special series of articles on Indochinese refugees in Michigan (See page 418). MSMS also continues its commitment to ask physicians to donate money to the Michigan Refugee Relief Fund. This fund was established by Governor Milliken in November as a non-profit organization to provide food, medicine and supplies for the refugees in Thailand and Cambodia. Interested physicians should contribute to the fund at Box 55-316A, Detroit, 48255. All contributions are tax deductible.

Features

- 412** Q/A on the Medicaid second surgical opinion program with Sen. Stephen V. Monsma; Willah Weddon
- 413** New Medicaid monitoring project watches for patients who abuse system
- 416** State mental health department reorganizes for the patient, last of state government series; Nancy Nowack
- 418** Indochinese refugees pose unusual personal health needs: Michigan Department of Public Health provides protocols for TB control, as *Michigan Medicine* continues series on refugees; Hector J. Inchaustegui, MD
- 428** MSMS Annual Scientific Meeting Nov. 18-19-20 has several courses on trauma and emergency care
- 432** All areas of future University Hospital in drawing board stage; Shelton Reece
- 434** The health of Michigan citizens — especially the rural, elderly and young — are targets of new Michigan Health Council push

Departments

- 406** Editorial; James H. Tisdell, MD
- 407** Letters
- 415** Health planning update; Dennis Paradis
- 420** Ad Index
- 430** Committees; Bonnie L. Groff
- 437** Meetings
- 438** Category I courses
- 444** Deaths
- 444** Classified
- 446** President's page

Our greatest impact on laws comes together as MSMS members

By James H. Tisdell, MD, Port Huron



This August 1980 issue of *Michigan Medicine* deals with legislation, primarily at a State level. This immediately brings to mind the effect that government has on the doctors of this state as they practice their profession: providing the medical care to the citizens of Michigan. How will we have some input on those people who propose and enact this legislation? Surely legislation affects us in a most telling way.

We can deal with this as individuals, or we can join together, by the thousands, in order to better influence the making of the rules and regulations under which we practice. It seems very clear to me that our greatest effect will be as members of an organization such as Michigan State Medical Society.

So, along with thoughts about legislation, I proceed to thoughts about membership.

We are thousands strong. We have committees state-wide, and in our Council, which constantly monitor legislative activities and report to us through *Medigram* and *Michigan Medicine*. We have the MSMS Department of Government Relations, headed by Bruce Ambrose, which takes the thoughts and the actions of our society to the Capitol in Lansing. These men and women are dedicated, and spend many hours of precious time in our behalf. The individual doctor as a member of Michigan State Medical Society has a number of professionals overlooking the legislature.

I believe alone we can have some influence, but as members of Michigan State Medical Society, we can have an influence many times stronger. How strong that influence will be for a member depends so much on what that member is willing to contribute to the medical society in time and talent.

Time and talent is what we need. We must have an infusion of new members, young and old, to continue to insure a constant supply of enthusiasm and wisdom to deal with the complex issues we face. My list of impressions from the eight-and-a-half-years I have served on the MSMS Council is headed by the swiftness with which new challenges are issued to us and the complexity of these challenges. Many of these issues involve legislation; and we have the people in our East Lansing headquarters who are daily meeting these challenges head-on.

Please join us and give of your time and talent. Be effective as an individual member of a strong medical society, working to benefit the thousands of doctors of Michigan and their millions of patients. Be a member of a strong medical society dedicated to the interest of our patients, the citizens of this state and nation, as we interact with legislators and legislation that affects medical care and our ability to administer it.

Doctor Tisdell is chairman of the MSMS Committee on Publications.

Michigan State Medical Society
Warren F. Tryloff, director

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Editor

Judith Marr

Michigan Medicine, the official journal of the Michigan State Medical Society, is dedicated to provide useful information for Michigan physicians about actions of the Michigan State Medical Society and contemporary issues, with special emphasis on socio-economics, legislation and news about medicine in Michigan.

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Diabetic retinopathy study a landmark in treatment

I am enclosing the text of an announcement that I would hope to have published in Michigan Medicine to have it brought to the attention of the widest possible number of Michigan State Medical Society members.

The Early Treatment in Diabetic Retinopathy Study is one of the largest clinical trials ever conducted, and it should have a major impact on the management of a disorder that causes blindness and visual disability in a large portion of the population.

As an additional reason why publicity for the present study among physicians is important, in a paper from the University of Michigan School of Public Health that appeared in the *Journal of the American Medical Association* published in June, 1979, it was pointed out that a survey of primary care physicians in Michigan revealed that only about 30 percent of family practitioners, and 40 percent of internists, were aware of the results of the previous major national diabetic retinopathy clinical trial, the Diabetic Retinopathy Study (DRS).

Since the DRS represents a landmark in the treatment of diabetic retinopathy, it is of utmost importance that all physicians be aware of

its conclusions, and of further clinical research efforts in this field.

Sincerely,

Robert N. Frank, MD
Associate Professor of
Ophthalmology
WSU School of Medicine

Announcement:

The Kresge Eye Institute, Wayne State University School of Medicine, seeks prospective patients to participate in the Early Treatment in Diabetic Retinopathy Study (ETDRS).

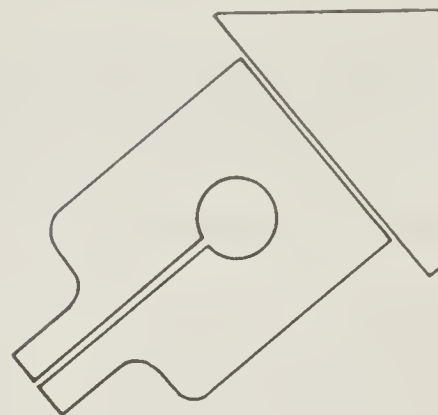
This nationwide study, funded by the National Eye Institute, seeks to determine if early photocoagulation treatment with the argon laser and/or drug therapy with aspirin is beneficial in the treatment of preproliferative diabetic retinopathy and diabetic macular edema.

A previous nationwide trial, the Diabetic Retinopathy Study (DRS), demonstrated the effectiveness of retinal photocoagulation for more advanced (proliferative) disease, but there is still significant morbidity which may be prevented by earlier laser treatment or by anti-platelet aggregation therapy. Twenty-one clinics, and over 4,000 patients, will participate in the ETDRS, whose duration will be five years.

Diabetic patients between the ages of 18 and 70 are eligible. They must have either preproliferative diabetic retinopathy ("cotton wool" spots, venous irregularity, intraretinal microvascular abnormalities, early new vessel formation, or extensive intraretinal hemorrhage) or macular edema (retinal thickening and/or lipid deposits in the macula). A history of previous photocoagulation or intraocular surgery, or several medical conditions, contraindicate participation in the study.

Inquiries about the ETDRS should be directed to Robert N. Frank, MD or Harold Weiss, MD, investigators, or to Lois Zapf, RN, or Robbie Crosby, MT (ASCP), study coordinators, at the Kresge Eye Institute, Wayne State University School of Medicine, 3994 John R Street, Detroit, 48201, (313) 577-1320.

LETTERS



Family Practice Day abstracts due

Family practice residents, family physicians, allied health professionals, and medical students are invited to submit abstracts for papers to be presented at Michigan Family Practice Research Day IV to be held on Nov. 6, at the University Club of Michigan State University.

Family practice research papers will be read during the morning session. Presentations will be limited to 10 minutes apiece, with five minutes for questions. A didactic session and small group discussions on topics in family medicine research will be held in the afternoon. Jack H. Medalie, MD, MPH, editor of the text *Family Medicine, Principles and Applications*, will deliver the keynote address at an evening banquet, after which awards for the best papers will be announced.

Those wishing to present a paper on Nov. 6 must submit an abstract in advance to the Research Day Planning Committee. Abstracts must be submitted by Sept. 25.

For further information please contact Doug McKeag, chairman, Family Practice Research Day Committee, B-100 Clinical Center, Michigan State University, East Lansing, 48824, 517/353-0770.

Thanks from SHOTS

The following letter was received recently by MSMS Director Warren F. Tryloff:

Thank you for the contribution to SHOTS for the fiscal year 1979-1980.

The continuing support from the Michigan State Medical Society is most appreciated.

Sincerely,

John G. Ditzhazy
Administrative Director
Statewide House Officers
Training System, Inc.
Lansing

HB 4555 had center stage in state's medical legislation this year

By W. E. Maldonado, MD, Lansing

It's a pretty sure thing that Blue Cross Blue Shield of Michigan will take on a new form in the near future. Versions of a bill — HB 4555 — have been passed by both the Michigan House of Representatives and Senate to reform the state's giant health care insurer.

Differences between the House and Senate versions have sent the bill into a conference committee of the two houses during the summer recess. What emerges will be the blueprint for BCBSM reorganization.

MSMS governmental affairs work during the past year has been devoted almost exclusively to HB 4555. Any report of legislative activity has to be made up in large part of an account of what MSMS has been doing and to projections of what the bill will mean.

MSMS activity in the Senate, the most recent to act on HB 4555, was directed toward two specific goals: 1) To assure continuation of per-case participation for physicians; and 2) To avoid the one percent per year cost deflator advocated by Senator Edward C. Pierce, MD.

As enacted by the Senate, a participating provider by definition is one who can be reimbursed by BCBSM either through "a full participating contract or separate and individual contracts on a per claim basis." The House version is indistinct as to whether per-case reimbursement is provided; it does not prevent such payments. The Senate version is much clearer on per-case participation.

This will be a matter for conference committee, and some disagreement as to specificity is indicated by House members.

As reported by the Senate Commerce Committee, the bill provides

Doctor Maldonado is chairman, MSMS Committee on State Legislation and Regulation.

for implementation of the House formula for cost containment, which basically would reflect the annual change in consumer price index.

At the motion of Senator Edward C. Pierce, MD, the committee added a phrase to reduce the House formula by one percent per year for six years, and henceforth tie it to the CPI. In committee of the whole, the Senate reversed itself on the Pierce amendment and adopted 15 to 14 an amendment by Senator Donald C. Bishop to delete the Pierce language. This reversal, which eliminates the "deflater," emerged through the final Senate vote.

The Bishop amendment would not have occurred without the active help of several hundred physicians.

President John R. Ylvisaker, MD, wrote to every member of MSMS after the Senate Commerce Committee action, urging members to contact their state senators and support the Bishop amendment in opposition to Senator Pierce's deflater. Hospitals, osteopathic physicians and dentists also went to the "grass roots." The response by members of the provider coalition certainly was the vital factor on the issue.

Resume of the bill with major Senate-House differences

The perception in the Legislature is that Blue Cross Blue Shield is the dominant force in the health care economics of the state. It provides coverage for medical and hospital care to nearly five and one-half million persons, more than 60 percent of the state's population; it has contracts with all but one of the hospitals in the state and with some 71 percent of the physicians. It administers the federal Medicare program.

In recent years, BCBSM has been the subject of considerable controversy. Its critics charge the corporation with being unduly secretive, un-

responsive to consumer interests, and not vigorous enough in cost containment efforts. It is also often maintained that the rates paid for Blues coverage in Michigan are higher than rates for comparable coverage in other states. Some persons have been upset at increases in administrative expenses, including the increases in the compensation provided the chief executive officer.

Much of the criticism has been centered on the nature of the board of directors — critics argue that it has been dominated by providers and has been subject to excessive management influence.

The controversy surrounding the Blues is compounded by the fact that the state's authority to regulate the Blues is not clearly defined under present law. A 1978 Michigan Supreme Court decision, *Blue Cross & Blue Shield of Michigan v. Insurance Commissioner*, held that the commissioner's statutory authority to approve the rates charged to the Blues' customers and the rates of payment to hospitals applies only to hospital services and that the statutes do not state what standards are to guide the commissioner in exercising that authority.

It is argued that since the Blues' powerful position in the health care marketplace has been achieved due to advantages it has been granted in statute, the public has a right to see that the corporation's influence is used in the public interest.

These concerns prompted the introduction of HB 4555, a bill intended to clarify the regulatory authority of the state, give the Blues' subscribers a greater voice in the formulation of the corporation's policies, and make use of the corporation's influence in imposing cost containment measures.

Some critics of the bill as it passed the House claimed that the bill went too far in regulating the



Blues and imposed unnecessary restrictions which could damage the corporation's viability in the market. Others felt the bill did not go far enough in its cost containment provisions.

Content

The bill would repeal Public Acts 108 and 109 of 1939 under which BCBSM operates and replace them with the Non-Profit Health Care Corporation Reform Act. While the bill would apply to any nonprofit health care corporation, Blue Cross and Blue Shield of Michigan is the only such corporation in the state. The effective date of the act would be January 1, 1981.

Among other things, the bill would:

- **Board of Directors:** Reorganize the board of directors so that there would be no more than 35 voting members, no more than 25 percent of whom would represent provider groups. Two directors, one of whom would be a retiree, would represent non-group subscribers — those customers paying individually for their own coverage. The board would also include four representatives of the public, two of whom would be at least 62 years old, appointed by the Governor with the advice and consent of the Senate. The bill requires the board to contain physicians and hospital provider directors, and guarantees that one of the directors would be a pharmacist and one would be a nurse. The president of BCBSM would be a board member. The board would include at least one seat for collective bargaining groups

and proportional representation of non-group subscribers and of small, medium, and large subscriber groups.

The House version calls for a board of 31 on a 3-to-1 subscriber-provider ratio; two public members, one of whom would be appointed by the director of the Office of Services to the Aging, and one selected by the Insurance Commissioner.

- **Board Conduct:** Establish provisions for the conduct of board business, roll call votes, minutes, agendas, and the kinds of decisions which committees of the board could make. Subscribers could obtain copies of the minutes, but standards would be provided for the keeping of separate minutes not for disclosure. The corporation's bylaws would be subject to the review of the Attorney General.

The major differences with the House lie in requirements for roll call votes; a larger list of persons receiving minutes of BCBSM board meetings; and the number of votes to take action, the Senate requiring a majority of those present if there is a quorum, the House requiring a majority of those serving (at least 16).

Provider reimbursement

With the defeat of the Pierce amendment both bills regarding provider reimbursement arrangements would be tied to goals established for the corporation. The insurance commissioner would have to use those goals as standards for judgment in evaluating the adequacy of provider class plans filed by the corporation.

Essentially, the goals would en-

courage that there be an appropriate number of providers throughout the state to assure the availability of the services covered by the corporation's certificates, that health care providers meet and abide by reasonable standards of health care quality, and that the cost of services be tied to a formula involving the rate of inflation and the rate of real economic growth.

The cost goal would set the rate of change in the total corporation payment per member for each provider class at a figure no higher than the compound rate of inflation and real economic growth.

A provider class plan would be defined as a plan which included a reimbursement arrangement and a set of objectives related to the goals for a particular class of health care providers. The nature of the classes would be determined by the corporation. The Blues would be required to establish and implement procedures for involving a provider class and for involving subscribers in the development of a provider class plan. The bill would permit the corporation to negotiate with a provider class. These negotiations would be exempt from state common law and state statutory laws of trust, monopolies, and combinations.

The insurance commissioner would determine whether the corporation had met its goals for a particular class plan and would be obliged to take into consideration, among other things, the corporation's annual report to the commissioner; the overall balancing of the access, quality and cost goals; various sorts of societal trends, including changes in prices of goods and services that the cost formula did not account for; sudden changes in circumstances; court decisions; changes in health care practices and technology; recent federal and state health care legislation; and comments from providers, their representatives, and eligible interested persons.

The commissioner could find that the corporation had met its goals; that one or more of the goals had not been achieved but with acceptable reasons; or that one or more of the goals had not been achieved without acceptable reasons. In the first two cases, the plan would not be subject to further review for two years.

Here is roundup on key medical bills

By Bruce W. Ambrose

It may seem hard for MSMS members, leaders and staff to believe there were medical issues during the 1979-80 legislative session other than Blue Cross Blue Shield of Michigan reform.

But there were a number of other significant bills introduced and acted upon.

Key among them was PA 176, also known as HB 5582, which has the effect of delaying the Comprehensive Health Planning Council of Southeast Michigan's hospital bed reduction plan as much as 18 months.

PA 176 states that the CHPC-SEM plan does not meet the intent of the bed reduction legislation, and officially provides a one-year hiatus to work out the inequities of the plan.

The legislature is still intent, however, on proceeding with the bed reduction plan and with not reducing the designated number of excess beds (3,800).

Other bills of medical interest which saw legislative introduction during the past months (with resulting action and MSMS positions, if any) include the following:

House Bills

• HB 4058 — Medical Treatment Decision Act

Sponsor: Rep. David Hollister

A provision assuring individual rights to accept or refuse medical treatment to prolong life, and allow for appointment of an agent to act in the patient's behalf when patient is unable to act for himself. Physician, hospital liability waived.

Current status: House Public Health Committee.

MSMS position: Support.

• HB 4078 — Legalization of Laetrile

Sponsors: Reps. Kelsey, Trim, Bennett, et al.

The manufacture, prescribing or administration of laetrile would be legalized. The bill relieves the physi-

cian of liability or disciplinary action by the Michigan Board of Medicine if the patient's condition continues to deteriorate.

Current status: Passed by House. In Senate Committee on Health and Social Services.

MSMS position: Opposed.

• Substitute HB 4425 — Disclosure of Mental Health Recipients Records

Sponsor: Reps. Bennane, Trim, Hollister, et al.

The bill allows for the disclosure of mental health recipients' records between county and state mental health entities under defined circumstances and prescribes penalties for misuse.

Current status: Passed House with substitute; in Senate Committee on Health and Social Services.

MSMS position: No current position.

• Substitute HB 4909 — Hospices

Sponsor: Reps. Hollister, Forbes, Bryant, et al.

The Public Health Code would be amended to define, license and regulate hospices.

Current Status: Passed by House. On Senate floor, third reading.

MSMS position: Support.

• Substitute HB 5401 — Medical Examiner Investigator

Sponsor: Rep. VanSingel

The position of medical examiner investigator would be established thereby addressing a problem particularly noticeable in rural areas where it is often difficult and sometimes impossible to arrange for a medical examiner to be at the scene of a medical examiner case. The bill would address this problem by creating a new job classification of medical examiner investigator who need not be a physician.

Current status: Passed by House. In Senate Health and Social Services Committee.

MSMS position: Support.

• HB 5868 — Medicaid Administration/Provider Participation

Sponsor: Rep. Kehres

Amends the Social Welfare Act

to specify responsibility for administration of the Medicaid program. Adds conditions for provider participation, grounds for action to limit or refuse provider participation and director's right to hold hearings regarding such. Facilitates action by the Attorney General to investigate and prosecute for fraud and abuse.

Current status: Passed by House. In Senate Health and Social Services Committee.

MSMS position: Seek amendments.

Senate Bills

• SB 157 — Medicaid Abortions

Sponsor: Sen. Fredericks, et al.

The legislation would prohibit abortions as a service provided to a recipient of medical assistance (Medicaid), unless the abortion is necessary to save the life of the mother.

Current status: Senate Health and Social Services Committee. A motion to discharge the bill from the Committee failed.

MSMS position: Opposed.

• SB 374 — Repeal of Drug Control License

Sponsor: Sen. DeGrow and Geake

Would repeal Section 17745 of the Public Health Code which requires physicians who routinely dispense drugs from their offices to obtain a Drug Control License.

Current status: Passed Senate; in House Committee on Public Health.

MSMS position: Support with amendments.

MSMS position: Opposed.

• SB 886 — Physician's assistants

Sponsor: Sen. G. Hart, Pierce, Kelly, et al.

A physician's assistant would be required to disclose his/her status when examining a patient.

Current status: Senate Committee on Health and Social Services.

MSMS position: Support.

Mr. Ambrose is manager, MSMS Department of Governmental Relations.

Medicaid mired as usual in appropriations complications

By Sherry N. Wellman, MSMS staff

During the course of a normal legislative year, one would expect that by the end of June, the state budget for the next fiscal year would be enacted and the Legislature would adjourn for the traditional summer recess.

However, at the time of the 1980 recess, supplemental appropriations necessary for the remainder of the current year faced gubernatorial veto, and substantive consideration of appropriations for the next fiscal year, beginning Oct. 1, had been deferred until the fall.

The overriding reason for the budgetary stalemate is the current economic situation nationwide, which, particularly in Michigan, makes the recession of 1974 look good by comparison. What causes the state budget-makers more concern than the 1974 experience are projections that it will be at least another 18 months before we reach the bottom of this cycle and start on an economic upswing.

Many of the reasons for Michigan's situation are directly related to the state's heavy reliance on the automobile industry. The Chrysler situation has forced the state to borrow money from other sources in order to fulfill its financial commitment to the company.

The most obvious effect of the automobile slump has been in unemployment figures. Michigan's unemployment figure now stands at 14 percent, double the national average. In addition, Michigan has the lowest rate of personal income growth in the country and general state revenues are down by six percent, causing the bonding sources to lower Michigan's rating.

The state budget most affected by the economic conditions has been social services. One out of every 10 families in Michigan is now on some

sort of public assistance and the numbers are expected to grow as unemployment and health insurance benefits are exhausted. The ADC caseload now stands at approximately 225,000 and another 85,000 cases are on General Assistance. If Chrysler should fail, 50,000 to 85,000 new families would be eligible for welfare.

The soaring rise in the welfare caseload has had a predictable effect on the social services budget, particularly in Medicaid, with funds budgeted for this year expected at this writing to be depleted by mid-July.

The Michigan Department of Social Services predicted the situation early this year, but the Legislature took no action on a supplemental appropriations bill until just before the summer recess. Passage of the \$161 million appropriation should have enabled the Department of Social Services to continue Medicaid reimbursements to providers throughout the summer and maintain funding until the new fiscal year, Oct. 1.

Abortion issue complicates

However, the Legislature tacked on language limiting funding for abortions to only \$1 and prohibiting any reimbursements related to abortions from the physician, hospital and pharmaceutical services line accounts.

Governor Milliken, an avowed supporter of state-funded abortions for the poor, announced he intends to use his veto powers to remove the \$1 limitation and the abortion prohibition. However, given the way in which the bill is written, the Governor must veto the entire line accounts for physicians, hospitals and pharmaceuticals in order to make his point.

That move puts the three affected provider groups back where they were before the supplemental — without sufficient funds to meet Medicaid reimbursements after mid-July.

Since the legislature has gone home for the summer, state budget officials will be forced to make a tough policy decision on whether to make physicians, hospitals and pharmaceutical service providers continue without being reimbursed for their services, or to make changes in the state's accounting procedure so that payments can be charged to the next fiscal year. In accounting terms, that would be abandoning the accrual system for the less-preferred cash accounting system.

Even if the state manages to devise a method to continue payments to the affected Medicaid providers until Oct. 1, the battle between the governor and the legislature over abortions has already been stated in current versions of 1980-81 Medicaid budget bills and could jeopardize funds for next year.

MSMS committee reaction

At the July meeting of the MSMS Medicaid Liaison Committee, there appeared to be an uneasy acknowledgement between the MSMS representatives and state officials, that Michigan physicians would once again be forced into a position of subsidizing the Medicaid program.

David Siegel, MD, chairman of the committee, commented that physicians are well aware of the state's economic crisis, and cautioned that we could see a repeat of 1974-75 when Medicaid patients were forced into more expensive treatment centers than physician's private offices.

John Dempsey, director of the Michigan Department of Social Services, noted that the situation could become extreme if the proposed Tisch amendment passes this fall. He predicted that, with the Tisch amendment, the State could not secure enough funds to equal the federal matching program necessary under Medicaid and that the program would have to be abandoned in Michigan.

Ms. Wellman is Coordinator for Public Policy and Political Affairs, MSMS Department of Government Relations.

Sen. Monsma sees a balance in Medicaid second opinions

By Willah Weddon, special to Michigan Medicine



Sen. Monsma

As chairman of the Michigan Senate Appropriations Committee's Subcommittee on Social Services, Sen. Stephen V. Monsma (D-Grand Rapids) has become involved in the Medicaid mandatory second surgical opinion program.

The former Calvin College professor discussed the program in a frank and friendly fashion during a recent interview in his Capitol office. He managed to appear unhurried, despite a hectic schedule.

Here in Q-A style, is the gist of the interview:

Q: Can you give me the background of the second surgical opinion requirement the Department of Social Services (DSS) now has in effect?

A: Public Act 110 was passed in the summer of 1979. This act appropriated state funds to the DSS for the year ending Sept. 30, 1980.

Part of Section 66 of this Act reads: "A mandatory second opinion system shall be implemented for selected elective hospital and physi-

cian services for Medicaid recipients before January 1, 1980."

When this was going through, the DSS first came up with the proposal that the department would approve selective, elective surgeries. The department would have decided if a person should or should not have an operation.

I felt, and the subcommittee felt, this was not a good way to go. You would have, in effect, a bureaucrat making a medical decision. So, as an alternative, we went to a second opinion by another physician. It was up to the Appropriations Committee to determine how the law went into effect.

Q: Isn't there some question about a law being made in an appropriations bill?

A: You cannot amend an existing law by a 'boiler plate' line in an appropriations bill. But you can specify the terms and conditions of how money will be spent, as long as you do not violate existing law.

Q: That is a pretty fine line, isn't it?

A: It is. This issue came up in regards to Medicaid patients' abortions. Att. Gen. Frank Kelley ruled that the basic enabling Act for Medicaid would have to be amended to prohibit paying for recipients' abortions.

Q: You are aware the MSMS House of Delegates has called for the repeal of the state law mandating second surgical opinions?

A: Yes, I understand they have.

Q: Should they have asked the Appropriations Committee to change its action, rather than decide to go to the legislature to change the law?

A: No, the repeal would have to be passed by the entire Legislature and signed by the Governor.

Q: Unless it is repealed, the second opinion program remains the law?

A: Yes. But the program expires on Oct. 1 of this year and next year's appropriations bill will have to include it, or it will lose its legisla-

tive mandate. Maybe the DSS could continue the second opinion program on the department's own initiative, but the program would not have the legislative mandate.

Q: How would that work?

A: The DSS might be able to continue the program on its own, as long as the legislature is silent. Of course, we might get language in the bill saying DSS could not require second surgical opinions.

The DSS does have some departmental discretion. I suspect if it would try to continue the second opinion program on its own, there would be a basis for challenge in the courts that it was exceeding its authority. However, the DSS would not be creating a new program. It would be implementing the law in order to reimburse physicians for services provided and this could be interpreted as some of the DSS' administrative discretion.

Q: When the department draws up rules, don't they have to be approved by the Joint Administrative Rules Committee of the Legislature?

A: Again, there's a distinction here. The DSS can make certain administrative decisions without going through the administrative rules process. But they have to go through the process if they are establishing policy. That is why Sec. 66 was put into this bill, as it was the legislative intent and the department could not be challenged as exceeding its authority.

Q: The director of the Medicaid Planning Division of the DSS told me he had wanted mandatory second opinions since November 1978, as a means of saving funds. Apparently he convinced the subcommittee.

A: Yes. We changed the method; but we did agree this would be an avenue for cost-savings.

Q: Some say this second opinion program will cost more, not less.

A: Well, yes, it is going to cost some money. You have to pay physicians giving the second opinions. The savings will come when a sur-

geon will not do what otherwise he would have done . . . and it makes sense that two surgeons will reach other conclusions and some patients won't have some operations.

Q: It also is said that within six months many operations still have to be performed. So it may look good on paper for six months?

A: This program is based on the assumption that no surgery will be done unless it is absolutely necessary. From the medical point of view there is a certain percentage of operations that surgeons will not agree upon.

Q: Physicians do not object to a patient obtaining a second opinion on a voluntary basis. But if I were receiving Medicaid, I would think I was being discriminated against if I was told I had to go see another surgeon assigned to my case by the DSS. Won't those patients feel that way?

A: At the bottom line, the question is how to provide the best medical care for the minimum amount of money.

The second surgical opinion program is part of the legislature's "boiler plate" language attached to the appropriations bill to contain costs. Now that the Michigan economy is getting softer it means those qualifying for Medicaid tend to go up and revenues to go down. We have to make some difficult choices. We did cut out all chiropractic services and obviously the chiropractors weren't pleased.

I would rather go to second opinions in certain elective procedures given these financial restrictions and save some money there (I'm assuming, although it hasn't been proven), than go to something arbitrary like cutting out eye glasses for senior citizens.

As a legislator, I have a certain responsibility to Medicaid patients, to make sure they receive full and adequate care; a responsibility to the health care community, that they receive appropriate reimbursement without undue harassment of red tape. I also have a responsibility to the taxpayers who have to foot the bill. Sometimes you have to balance these three things.

Patients who abuse Medicaid targets of new monitoring

A successful pilot project to reduce abuse of medical services by Medicaid recipients is being expanded to several Michigan counties.

The Michigan Department of Social Services' Recipient Monitoring Project is now underway in Wayne, Genesee, Oakland, Macomb, and Kent counties, after proving successful in reducing Medicaid recipients' abuse of nonemergency ambulatory services in Wayne and Genesee pilot projects.

The monitoring project is slated next for Bay, Berrien, Calhoun, Ingham, Jackson, Kalamazoo, Muskegon, Saginaw, St. Clair and Washtenaw counties. It became effective in the first five counties on May 1.

"The recipient monitoring program is directed toward those Medicaid patients who have a demonstrated pattern of abusing Medicaid benefits," explains David Siegel, MD, chairman, MSMS Medicaid Liaison Committee.

"Drug abuse or 'prescription shopping' is one of the greatest areas of concern," he continues. "The first category of Medicaid recipients tagged for monitoring were those who obtained, on the average, more than 60 scripts per quarter!"

Doctor Siegel was answering the queries of a concerned Grand Rapids internist when he made the above comments. His explanation may be of interest to many Michigan physicians.

The monitoring project allows MDs to decide whether or not to serve as a "primary provider" for one or more Medicaid recipients in order to control their usage of medical services.

According to the Department of Social Services Medical Assistance Program Bulletin of May 1, the decrease in the overall misuse of medical and pharmacy services has been substantial in their recipient monitoring pilot projects.

"Although relatively few recipients will be involved in this project,

the overall impact of their use of nonemergency services is significant," says the *Bulletin*.

The expanded recipient monitoring project will involve a limited number of recipients, the *Bulletin* emphasizes, and consists of two separate control mechanisms.

One mechanism limits identified recipients to specific providers who agree to be their primary source of medical services. The other controls use of medical services by requiring recipients to obtain prior authorization for all nonemergency services. Special cards identify the mechanisms controlling the selected recipients' use of services.

"All of us have seen the publicity given to those few physicians who have abused the Medicaid or Medicare programs," says Doctor Siegel.

"The Michigan State Medical Society has been firmly on-record supporting identification and prosecution of fraudulent providers, including physicians, and we offer the expert services of volunteer physicians who review cases of suspected abuse for the state Medicaid program.

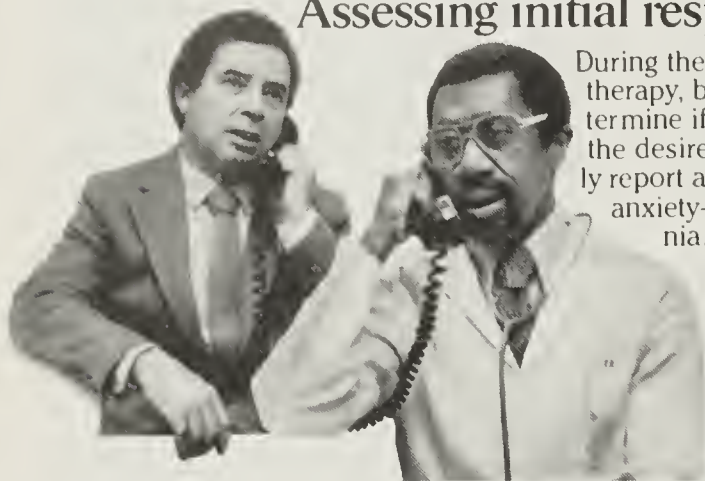
"However, we have long maintained that the state has done little or nothing when it comes to the identification of patients who may be guilty of abusing the Medicaid program.

"We believe the recipient monitoring project being undertaken by the Department of Social Services has the potential of finally addressing the issue of patient abuse of the program."

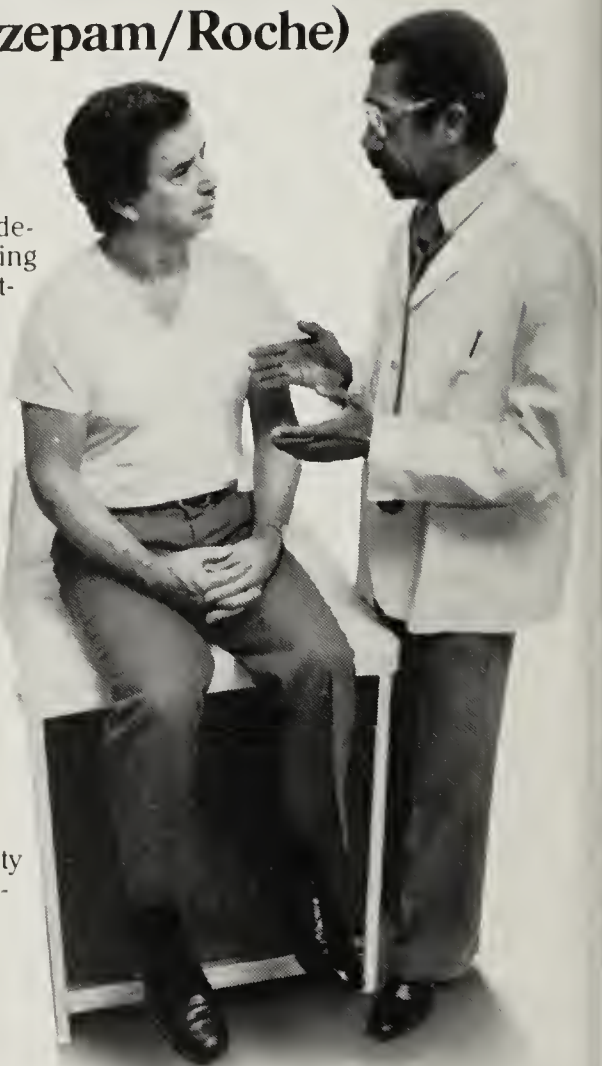
If a physician has concerns regarding a Medicaid recipient's misuse of services, the physician is encouraged to contact Medicaid Monitoring, Bureau of Health Services Review, Medical Services Administration, P.O. Box 30037, Lansing, 48909, 517/373-0953.

Monitoring patient response to Valium® (diazepam/Roche)

Assessing initial response to therapy



During the first follow-up visit after initiating therapy, both physician and patient should determine if Valium (diazepam/Roche) is having the desired effect. Most patients will promptly report a feeling of relaxation and relief of anxiety-linked symptoms such as insomnia, headaches, palpitations and hyperventilation. You will probably observe that the patient is calmer and more relaxed. If, however, patient response does not measure up to expectations, a reevaluation of the patient's profile with modification of the dosage regimen should be considered.



Making dosage adjustments

START	ADJUST

With any psychoactive medication it is good medical practice to initiate therapy at base dosage levels and titrate to the patient's needs. With Valium, experience has shown that 5 mg t.i.d. is usually sufficient although some patients with severe or persistent anxiety may require higher dosages initially. In geriatric or debilitated patients, the recommended dosage is 2 to 2½ mg once or twice daily.

When anxiety fluctuates, as is common with most patients, the dosage may be adjusted as needed during the course of therapy; three strengths in scored tablets give you unmatched flexibility and simplicity in individualizing dosage.

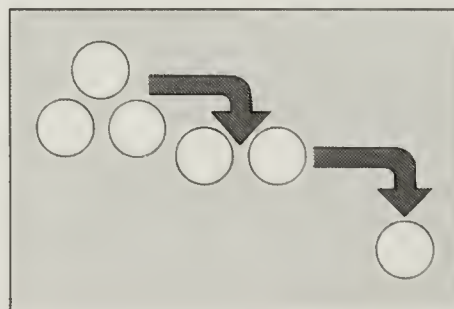
Evaluating progress toward therapeutic goals

SET GOALS						
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30	31		

At the beginning of therapy it is now common practice for both physician and patient to establish treatment goals and to estimate the amount of time needed to achieve them. Then the patient knows what to expect and when to expect it.

Some physicians find that compiling a checklist of presenting symptoms and complaints is useful for assessing the patient's response from visit to visit. In this way, progress toward attainment of the therapeutic goal is reviewed at regular intervals. As patients feel their symptoms abate and begin to develop insight into the sources of their anxiety and psychic tension, the checklist can be expected to dwindle.

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When you decide to discontinue therapy, tapering dosage is good medical practice. Although rarely necessary after short-term treatment with Valium, gradual dosage reduction is advisable for patients who have been on extended therapy. This gradual discontinuance should preclude either recurrence of pretreatment symptoms or development of untoward side effects. Symptoms of withdrawal have almost always been associated with abrupt discontinuance of therapy at higher dosages taken continuously over long periods of time.

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Indications: Tension and anxiety associated with anxiety disorders; transient situational disturbances and functional or organic disorders; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology; spasticity caused by upper motor neuron disorders; atetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

The effectiveness of Valium (diazepam/Roche) in long-term use—that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication. Abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms similar to those with barbiturates and alcohol have been observed with abrupt discontinuation, usually limited to extended use and excessive doses. Infrequently milder withdrawal symptoms have been reported following abrupt discontinuation of benzodiazepines after continuous use, generally at higher therapeutic levels, for at least several months. After extended therapy, gradually taper dosage. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed. Drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed or with latent depression or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported, should these occur, discontinue drug. Isolated reports of neutropenia, jaundice, periodic blood counts and liver function tests advisable during long-term therapy.

Dosage: Individualize for maximum beneficial effect. **Adults:** Tension, anxiety and psychoneurotic states: 2 to 10 mg b.i.d. to q.i.d. alcoholism: 10 mg t.i.d. or q.i.d. in first 24 hours then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm: 2 to 10 mg t.i.d. or q.i.d. adjunctively in convulsive disorders: 2 to 10 mg b.i.d. to q.i.d. **Geriatric or debilitated patients:** 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) **Children:** 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

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By Dennis Paradis, Director
MSMS Physician/HSA Support Center



Future of HSAs challenged

Addressing the American Health Planning Association in June in San Francisco, Nathan Stark, undersecretary of the Department of Health and Human Services (formerly HEW), gave an ultimatum to HSAs. Mr. Stark indicated future funding of HSAs would be dependent on the ability of HSAs to demonstrate their effectiveness. The clear connotation was that an increased emphasis on cost containment will be expected in any demonstration of effectiveness.

Teeth for appropriateness review?

Appropriateness review, which health planners are just beginning, is generally considered to be the 'weak sister' of health planning regulation because it has no sanctions attached for noncompliance. However, at a speech in San Francisco, HHS Undersecretary Stark confirmed that a proposal was being reviewed that would link appropriateness review compliance to Medicaid and Medicare reimbursement. If such a proposal were enacted, the health planning structure would have a tool to eliminate existing services that were deemed inappropriate. This type of tool would significantly strengthen the HSA regulatory authority.

Public Hearings on State Medical Facilities Plan

The State Medical Facilities Plan (SMFP) will be discussed at public hearings in late summer (schedule not yet determined). The SMFP divides the state into 71 areas and identifies the shortfall or excess of hospital and long-term care beds in each. Hospital bed need is determined by the controversial acute care bed need methodology. Nursing home beds are determined on a formula which has been criticized as inadequate in rural areas. The SMFP is not part of the bed reduction program, but is used as a touchstone for certificate of need reviews. Information about the public hearing schedule can be obtained from the Office of Health and Medical Affairs at 517/373-9650.

New day dawns for the patient at Department of Mental Health

By Nancy Nowack, Special to Michigan Medicine

"The consumer is paramount," says Frank M. Ochberg, MD, director of the Michigan Department of Mental Health, setting the tone for innovative re-organization of mental health care in the state. The consumer (client) is the emotionally disturbed/mentally ill or mentally retarded individual.

"The challenge," says Doctor Ochberg, a bit of fire in his eyes, "is how does a public system really listen and relate to its clients, many having IQs of less than 30?"

Leading the way by personally listening to experiences of ex-patients, Ochberg urges a re-establishment of dialogue between patient and physician, insisting the physician need not tell the patient what to do.

Michigan residents receive their mental health treatment through several major sources.

Last year community mental health agencies, which receive most of their funds from the state, provided out-patient treatment, including preventive, clinical and after-care services, for more than 15,000 persons. State psychiatric hospitals, maintained by the MDMH, served a total of more than 37,000 in-patients and out-patients, while some 134,000 persons received care in licensed psychiatric units of general and private hospitals. In addition, centers for the developmentally disabled provided both in- and out-patient services to more than 11,000.

A significantly large number of patients express positive (but not entirely positive) feelings regarding their care. Patient concerns today are insufficient services and elimination of abuse, with Michigan finding a slight emphasis on services.

DMH clients have various spokesmen and some speak louder than others — but the voice of the future seems that of the patients themselves as many form self-help groups, with the endorsement of the DMH.

"We want to help with this," says Doctor Ochberg, "but we have to

be careful not to help too much." Doctor Ochberg, gratified by the ex-patients' reception of DMH administrators and staff, sees clients gradually beginning to feel some ability to work with the DMH.

"It's a new day . . . it's changing," says Doctor Ochberg, with a broad smile.

Physicians seeking assistance with DMH-related problems may call their community mental health center or its mental health board member for a referral or consultation. Access to state facilities is also available through the local community mental health boards.

Community mental health boards' services may become increasingly important to physicians as the phenomenon of unemployment-related stress provokes a rise in both physical and mental illnesses.

The DMH, headed by Doctor Ochberg, has four major bureaus — staff; operations; planning, evaluation and policy; and administration. These bureaus, having recently come under re-organization, include 19 departments scheduled for attention pending the addition of staff. The DMH also contains the Office of Recipient Rights.

Bureau of Operations V.A. Stehman, MD, Deputy Director/Chief of Staff

This bureau is the service arm of MDMH headquarters, supporting regional offices, department facilities and community mental health programs. It does not provide clinical services, but is responsible for the monitoring of field operations and assurance of quality mental health

care. Its four functions are: resource development, licensure and accreditation and quality assurance of health care. Inherent in these functions are responsibility of monitoring the care and treatment of recipients of mental health care services.

Staff Bureau Wesley Pomeroy, Chief Deputy Director

Headed by the deputy director/chief of staff, this bureau includes: Office of Community Relations, Office of Equal Opportunity and Affirmative Action, Administrative Tribunal and Office of Intergovernmental Affairs.

Bureau of Administration Dan Brown, Deputy Director

This bureau is accountable for those functions related to all business, management and financial responsibilities of the department, with particular emphasis of the department's budget-decision process.

Bureau of Planning, Evaluation and Policy Sharon Miller, Deputy Director

This bureau is the policy developing arm of the department and assures data-based decision-making, participation of consumers and of experts in the DMH planning process. Major functions include: strengthened planning and advising process for consumers, families, advocates and providers of mental health services; policy and standards development; systems analysis and evaluation, and innovation initiatives. This component yields planning, analytical and policy standards documents for use by the director, the operational bureaus and other staff bureaus of the department.

Office of Recipient Rights Janet Coye, Director

This office guarantees patient's rights according to the Mental Health Code and MDMH policy.

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Each 1 mg Hydergine tablet contains dihydroergocornine mesylate 0.333 mg, dihydroergocristine mesylate 0.333 mg, and dihydroergocryptine (dihydro-alpha-ergocryptine and dihydro-beta-ergocryptine in the proportion of 2:1) mesylate 0.333 mg, representing a total of 1 mg.

They're in their late sixties, the beneficiaries of more liberal retirement laws and more enlightened attitudes toward the elderly. They're leading socially productive lives. But recently, without any clear cause, they had each begun to experience mild episodes of symptoms such as confusion, mood-depression, and dizziness. Their ability to function could have been jeopardized. That's when they became the beneficiaries of oral Hydergine therapy.



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Adverse Reactions: Serious side effects have not been found. Some sublingual irritation, transient nausea, and gastric disturbances have been reported. Hydergine tablets and sublingual tablets do not possess the vasoconstrictor properties of natural ergot alkaloids.

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MSMS Task Force on Indochinese Refugees dedicated to informing, coordinating MDs

By Hector J. Inchaustegui, MD, Royal Oak

The following articles are the second in a series on Indochinese refugees and their physical and emotional health needs. The series began in the July issue of *Michigan Medicine*, with statistics on the newcomers, parasite treatment protocols, and a description of MSMS efforts to help the refugees.

MSMS members who are interested in providing volunteer services to initially screen the refugees for medical needs are invited to contact the MSMS Task Force on Indochinese Refugees at MSMS headquarters, PO Box 950, East Lansing, 48823. A form for volunteering appears in the July 11 issue of *Michigan Medicine/Medigram*.

An MSMS ad hoc committee for the Indochinese refugees in Michigan was formed about two months ago. The task before the committee is to inform Michigan physicians about characteristics — cultural, nutritional, and epidemiological — of the people that are coming from Indochina.

There are several things we have to take into account whenever we talk about people from Indochina. The Indochinese are comprised of people from Cambodia, Vietnam, Laos and Thailand. These are people that have been displaced by world events that have taken place in their area of the world which have deprived them of their homeland and their means of livelihood.

The basic bulk of these people are farmers, having no land upon

which to survive. Starvation has ravaged their ranks and malnutrition has created a large problem. Some of the world's well-intended aid to these people has fallen into the hands of those who want to use it as a means of propaganda for themselves and as a way to demoralize the people who have already suffered enough.

Also, efforts to stop the starvation of these people have met with problems which are characteristic to these areas. As an example, we have sent a tremendous amount of milk. But because of a genetic deficiency of enzymes to metabolize lactose, this has been almost useless, as the children develop diarrhea and other problems from the milk.

In the United States, a group of voluntary efforts has come to the aid and resettlement of these Indochinese refugees. The effort has been well organized and has brought families to our country that are being sponsored by different organizations all over our 50 states. We have been successful in bringing these people to a new, free world.

But because of bureaucratic insufficiency and the number of people that are being resettled, a health problem of some degree is possible. We have to learn how to deal with diseases and problems which may be unfamiliar to some of us who have not been used to treating these people.

The goal of our task force is to create a voluntary force of doctors to screen these people as they come into the state for the problems they may be bringing with them. These problems may include things like malaria, paritosis and malnutrition, which are common among the people of Indochina. Some of us have not since medical school dealt with these prob-

lems. Although they do not really represent a problem for the areas where they will be resettling, they do represent a problem to those who are ill.

Because the refugees are going to be coming to different areas of our state, we are going to need to coordinate different groups that should comprise physicians, laboratory, nutritionists and other aides to make these people feel more welcome and make their adjustment to our society a little easier.

We have to understand and get acquainted with their customs; because, in our efforts to be helpful, sometimes we may give the wrong impression of what we are trying to do. We are not trying to make these people feel inferior, we are just trying to show them that our traditional western medicine can be a help to them, without interfering with their medical beliefs and with their cultural taboos.

Also, we have found by the statistics that about 75 percent of the children will have positive stools for parasites when two stools are done, and that about 25 percent of the adult population will be positive for hepatitis antigen B. These are facts that have to be known to protect physicians and also dentists that might be working on these people.

It is this kind of information the MSMS Task Force is dedicated to disseminating to Michigan physicians. And it is this kind of help we hope to foster across the state by coordinating efforts of physicians.

Doctor Inchaustegui is chairman of the MSMS Task Force on Indochinese Refugees

Refugees pose little public health threat, but personal health needs must be met

The following article is excerpted, with permission, from the "Special Report: Physical and Emotional Health Care Needs of Indochinese Refugees," of the Indochina Refugee Action Center, Washington, DC. It was compiled and written by Court Robinson, IRAC information specialist, who will make copies of his full report available on written request to IRAC, 1025 Fifteenth NW, Suite 600, Washington, DC, 20005.

Indochinese refugees arriving in this country have been subjected to prolonged conditions of severe physical and emotional stress. The marks of their ordeal are plain — these include significant personal medical problems and deep psychological wounds.

The full extent of our knowledge about the medical and emotional needs of the refugees is partially obscured by language barriers and cultural distance, but we do know that the problems which exist are basic to human life and well-being. The Indochinese refugees are neither a sickly nor an unstable people; they have weathered their hardships with remarkable stamina. They do, however, need special care and attention. The problems of the refugees need not threaten us, but rather should move us to respond more quickly. While we may never fully erase the scars of their violent uprooting and loss, we must do all that we are able in order to generate an efficient, effective and humane response to their needs.

The United States has ample means to devise comprehensive programs for physical and mental health care — yet we have been slow to act. Our tardiness has only aggravated the existing troubles. The Indochinese refugees coming to this country find that their problems often go uncared-for, either through poor coordination of services, lack of specific expertise, scarcity of resources, or simply an inability on the part of health care providers to locate the refugees once they reach our



A Cambodian refugee camp scene, as photographed by James W. Jordan of Governor Milliken's staff.

communities.

Several important improvements have recently been made in medical programs for refugees — improvements that should do much to clarify the functions and responsibilities of the many people involved in refugee health care. Increased attention, at all levels, is being focused on the emotional health problems of refugees, in an effort to ease the stress and concern of the difficult period of resettlement. There is still a pressing need, however, both to further define and coordinate the roles of the public and private agencies involved, and to enlarge the scope of health and mental health care throughout the whole resettlement program, so that services vital to adjustment will be available to all who need them.

Physical health

From the camps in Southeast Asia to communities in the United States, a host of individuals and a wide variety of international, national, and local organizations, are involved in providing medical care to the Indochinese refugees.

The United Nations High Commissioner for Refugees (UNHCR), in

cooperation with the host country's national government, and in collaboration with other international and national agencies, takes responsibility for the health and welfare of all refugees in the first asylum camps. Those refugees who are accepted for resettlement in the United States travel from the camps to transit centers, also administered by the UNHCR. The Intergovernmental Committee for European Migration (ICEM), provides medical screening* in the transit centers, and arranges transportation to the US. The Center for Disease Control (CDC), a branch of the US Public Health Service (USPHS), monitors this overseas screening and examines the refugees' health records at US ports of entry.

According to the US Public Health Service, once the refugees arrive in the areas of their intended resettlement, the primary responsibility

* Overseas screening consists of a preliminary, cursory examination for active tuberculosis, syphilis, infectious leprosy, and other excludable conditions, as designated by the Immigration and Naturalization Service (INS). Screening provided to refugees in the US is generally termed an "initial health assessment," and involves more extensive procedures.

INDOCHINESE/continued

for providing health services rests with the state and local health departments. The voluntary resettlement agencies, and the local sponsors who have been located for the refugees by the voluntary agencies, complement the efforts of the state and local health departments both by assisting the refugees in health-related matters, and by encouraging the donation of services by private physicians, clinics, and hospitals.

The medical services provided to the refugees are generally covered by the Medicaid program, which is administered by HEW's Health Care Financing Administration (HCFA). Though the expense for Medicaid benefits is normally shared between the state and the Federal government, in the case of the Indochinese refugees, the state's share of Medicaid expenditures is reimbursed, through special Federal legislation, by HEW's Indochinese Refugee Assistance Program (IRAP), which is administered by the Office of Refugee Resettlement, in the Office of the Secretary of HEW.

Many of the Indochinese refugees arrive in this country with significant health problems. Data pro-

vided by the US Public Health Service suggests the prevalence of the following conditions:

Intestinal	
parasites	31 percent
Anemia	29 percent
Skin conditions	28 percent

Malaria, Hepatitis B, and dental problems are also frequently encountered medical conditions. The incidence of tuberculosis among the refugees has been a subject of concern to some health officials.

While the medical troubles of the refugees warrant prompt attention and care, the majority of problems are not severe. Preliminary data from a recent sample-screening of incoming refugees conducted by the Center for Disease Control (CDC), indicated that only one-tenth of one percent required immediate hospitalization, and 94 percent were within the normal limits of good health. A Public Health Service team that assessed health care for Indochinese refugees on the West Coast reported:

"...when the existing systems are functioning well, as appears to be the case for a substantial majority of the arriving refugees, the risks to the American population are probably lower than those which characterize routine immigration."

Some refugees allowed waiver of immigration health restrictions

United States' laws and regulations exclude entry into the United States of aliens diagnosed abroad with active tuberculosis, untreated venereal disease, infectious leprosy, certain mental conditions including mental retardation and insanity, and chronic alcoholism and drug addiction.

Such aliens are eligible for a waiver of excludability if they meet certain Immigration and Nationality Act requirements and may enter the United States if their sponsor obtains a medical care provider in the United States who agrees to provide necessary care and is endorsed by the health department in whose jurisdiction the alien will reside.

On March 15, the Attorney General of the United States suspended the medical excludability for certain refugees until May 17.

This ruling applied only to the following conditions:

Mental Retardation
Past Attack(s) of Insanity
Active TB, Noninfectious
Infectious Leprosy

Refugees with these health conditions were allowed to enter the United States during that time without a waiver having been signed by the local health officer.

All refugees affected by the suspension of excludability were instructed orally and in writing to report to their local health department upon arrival at their destination. In addition, they received an information letter to be given to their sponsors. The sponsor is requested to contact the health department or other medical care provider.

— The "Circular," Vol. 42, No. 17,
April 28, 1980
Michigan Department of
Public Health

No serious threat

In other words, the refugees pose no serious health threat to the population at large. However, the provision of adequate, personal health care to the Indochinese refugees, has presented significant logistical problems. Hospital based services and emergency care pose no apparent difficulties; but the PHS team noted:

"The needs of refugees for ambulatory care, such as screening, diagnosis, immunization and other preventive care, and nutritional, dental and mental health care are not being adequately addressed."

The efforts by state and local health departments to provide satisfactory, timely medical care, have been greatly hampered by a number of procedural complications. These include:

- Overseas medical screening of the refugees has often been incomplete and inconsistently reported.
- State and local health departments have frequently not been provided with adequate information as to the number of refugees arriving, or their intended residence. Local health providers are thus hindered both in planning and promptly initiating service delivery.
- Funding resources are limited (in some places critically) for the provision of health services to refugees. Delays in Medicaid certification have also impeded the delivery of service.
- Language and cultural barriers present special difficulties.

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Physicians commonly find TB in refugees

uberculosis is one of the major health problems of Indochinese refugees.

According to the national Center for Disease Control in Atlanta, refugees whose medical screening abroad results in a classification of Class A TB (active or suspected active) or Class B TB (not active) should be re-evaluated after arrival in the United States.

The reason is, according to the Michigan Department of Public Health's "Circular" newsletter, that the classifications are based on limited diagnostic information. Conditions in the refugee camps make it difficult to provide medical evaluations as rigorous and accurate as those performed in this country. Says the "Circular":

The medical examinations . . . are limited by the large number of refugees that must be evaluated, the short time during which the refugees are at the center, and the diagnostic procedures available at the centers. Tuberculosis screening consists of a medical history, cursory physical examination, chest X-ray, and, if indicated, sputum smears. Culture for *M. tuberculosis* is not currently available.

Available data indicate that many Class A-TB refugees turn out not to have "active" disease whereas some Class B-TB refugees do.

Therefore, all Class A-TB and Class B-TB refugees should be carefully re-evaluated to be sure that Class A-TB refugees who do not have "active" disease are not exposed to the potential toxicity of multiple-drug antituberculosis therapy and that those Class B-TB refugees who do have "active" disease receive adequate therapy. Some refugees who were not certified abroad as either Class A-TB or Class B-TB will be found to have current disease in need of multiple drug therapy because an unknown number will develop disease after the overseas screening and some may not have had their disease detected by the screening procedures.

According to the Center for Disease Control's "Morbidity and Mortality Weekly Report" of Aug. 24, 1979:

Follow-up and treatment after arrival in the United States

If treatment has not been started abroad on a refugee with Class A tuberculosis, specimens should be obtained for bacteriologic examination (smear and culture) and for drug-susceptibility tests. Depending on the examining physician's clinical judgment, treatment may be started after specimens have been obtained or deferred until the results of the tests are available.

Treatment started in the United States should follow CDC recommendations that Class A tuberculosis cases with positive bacteriology and/or cavitory lesions on chest X ray be started on treatment consisting of isoniazid (INH), rifampin, and ethambutol. Ethambutol has been included because, based on drug-resistance studies done in the United States, it is estimated that approximately 10 percent of the refugees with tuberculosis may

(continued on page 427)

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WARNINGS: If tolerance develops, the recommended dose should not be exceeded in an attempt to increase the effect, rather, the drug should be discontinued. Tenuate may impair the ability of the patient to engage in potentially hazardous activities such as operating machinery or driving a motor vehicle; the patient should therefore be cautioned accordingly. **Drug Dependence:** Tenuate has some chemical and pharmacologic similarities to the amphetamines and other related stimulant drugs that have been extensively abused. There have been reports of subjects becoming psychologically dependent on diethylpropion. The possibility of abuse should be kept in mind when evaluating the desirability of including a drug as part of a weight reduction program. Abuse of amphetamines and related drugs may be associated with varying degrees of psychologic dependence and social dysfunction which, in the case of certain drugs, may be severe. There are reports of patients who have increased the dosage to many times that recommended. Abrupt cessation following prolonged high dosage administration results in extreme fatigue and mental depression; changes are also noted on the sleep EEG. Manifestations of chronic intoxication with anorectic drugs include severe dermatoses, marked insomnia, irritability, hyperactivity, and personality changes. The most severe manifestation of chronic intoxications is psychosis, often clinically indistinguishable from schizophrenia. **Use in Pregnancy:** Although rat and human reproductive studies have not indicated adverse effects, the use of Tenuate by women who are pregnant or may become pregnant requires that the potential benefits be weighed against the potential risks. **Use in Children:** Tenuate is not recommended for use in children under 12 years of age.

PRECAUTIONS: Caution is to be exercised in prescribing Tenuate for patients with hypertension or with symptomatic cardiovascular disease, including arrhythmias. Tenuate should not be administered to patients with severe hypertension. Insulin requirements in diabetes mellitus may be altered in association with the use of Tenuate and the concomitant dietary regimen. Tenuate may decrease the hypotensive effect of guanethidine. The least amount feasible should be prescribed or dispensed at one time in order to minimize the possibility of overdosage. Reports suggest that Tenuate may increase convulsions in some epileptics. Therefore, epileptics receiving Tenuate should be carefully monitored. Titration of dose or discontinuance of Tenuate may be necessary.

ADVERSE REACTIONS: **Cardiovascular:** Palpitation, tachycardia, elevation of blood pressure, precordial pain, arrhythmia. One published report described T-wave changes in the ECG of a healthy young male after ingestion of diethylpropion hydrochloride. **Central Nervous System:** Overstimulation, nervousness, restlessness, dizziness, jitteriness, insomnia, anxiety, euphoria, depression, dysphoria, tremor, dyskinesia, mydriasis, drowsiness, malaise, headache; rarely psychotic episodes at recommended doses. In a few epileptics an increase in convulsive episodes has been reported. **Gastrointestinal:** Dryness of the mouth, unpleasant taste, nausea, vomiting, abdominal discomfort, diarrhea, constipation, other gastrointestinal disturbances. **Allergic:** Urticaria, rash, ecchymosis, erythema. **Endocrine:** Impotence, changes in libido, gynecomastia, menstrual upset. **Hematopoietic System:** Bone marrow depression, agranulocytosis, leukopenia. **Miscellaneous:** A variety of miscellaneous adverse reactions has been reported by physicians. These include complaints such as dyspnea, hair loss, muscle pain, dysuria, increased sweating, and polyuria.

DOSAGE AND ADMINISTRATION: Tenuate (diethylpropion hydrochloride): One 25 mg tablet three times daily, one hour before meals, and in mid-evening if desired to overcome night hunger. Tenuate Dospan (diethylpropion hydrochloride) controlled-release: One 75 mg tablet daily, swallowed whole, in mid-morning. Tenuate is not recommended for use in children under 12 years of age.

OVERDOSAGE: Manifestations of acute overdosage include restlessness, tremor, hyperreflexia, rapid respiration, confusion, assaultiveness, hallucinations, panic states. Fatigue and depression usually follow the central stimulation. Cardiovascular effects include arrhythmias, hypertension or hypotension and circulatory collapse. Gastrointestinal symptoms include nausea, vomiting, diarrhea, and abdominal cramps. Overdose of pharmacologically similar compounds has resulted in fatal poisoning, usually terminating in convulsions and coma. Management of acute Tenuate intoxication is largely symptomatic and includes lavage and sedation with a barbiturate. Experience with hemodialysis or peritoneal dialysis is inadequate to permit recommendation in this regard. Intravenous phentolamine (Regitine®) has been suggested on pharmacologic grounds for possible acute, severe hypertension, if this complicates Tenuate overdosage.

Product Information as of April, 1976

MERRELL-NATIONAL LABORATORIES Inc.
Cayey, Puerto Rico 00633

Direct Medical Inquiries to
MERRELL-NATIONAL LABORATORIES
Division of Richardson-Merrell Inc.
Cincinnati, Ohio 45215, U.S.A.

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References: 1. Citations available on request from Medical Research Department, MERRELL-NATIONAL LABORATORIES, Cincinnati, Ohio 45215. 2. Hoekenga, M.T., O'Dillon [Dillon], R.H., and Leyland, H.M. A comprehensive review of diethylpropion hydrochloride. In: Central Mechanisms of Anorectic Drugs, S. Garattini and R. Samanin, Ed., New York, Raven Press, 1978, pp. 391-404.

Merrell

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**Overweight may not always be simple...
complications can develop*.
Complicated or not...**

Tenuate[®] Dospan[®] ^{IV} **(diethylpropion hydrochloride NF)** **75 mg. controlled-release tablets**

A useful short-term adjunct in an indicated weight loss program.

Overweight patients in certain diagnostic categories often require strict appetite control and a successful program of weight reduction may tend to diminish the incidence or severity of the complications in some patients. Diethylpropion hydrochloride has been reported useful in such patients and while it is not suggested that Tenuate itself in any way reduces the complications of overweight, it may have a useful place as a short-term adjunct in a prescribed dietary regimen. **Tenuate should not be administered to patients with severe hypertension; see additional Warnings and Precautions on the opposite page.**

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Many patients, on the other hand, present with excess fat but no disease. While this condition is often termed uncomplicated obesity, complications of both a social and a psychologic nature may be distressingly real for the patients. In these cases, a short-term regimen of Tenuate can help reinforce your dietary counsel during the important early weeks of an indicated weight loss program.

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**Tenuate—it makes sense.
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*Studies have shown that obesity is associated with an increased incidence of hypertension, symptomatic heart disease, adult-onset diabetes, and other diseases.

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For prescribing information see opposite page

α

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Congestive heart failure	Allergic rhinitis
Ventricular hypertrophy	Hepatic disease
Hyperglycemia	Hyperuricemia
Diabetes mellitus	Gouty arthritis
Bronchial asthma	Sulfonamide hypersensitivity

Like any antihypertensive, use with caution in severe coronary insufficiency, recent myocardial infarction, cerebrovascular disease or chronic renal failure.

work/play—normal hemodynamic responses to exercise maintained.

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cardiac output—tends to return to control values during long-term therapy.

blood flow—preserved in kidney.

No Single Advantage Determines Drug Choice.

Other factors must include:

The drug's effectiveness in a given patient, its side effects, warnings, precautions, tolerance, etc. A rational therapeutic choice depends on a careful assessment of all such factors.

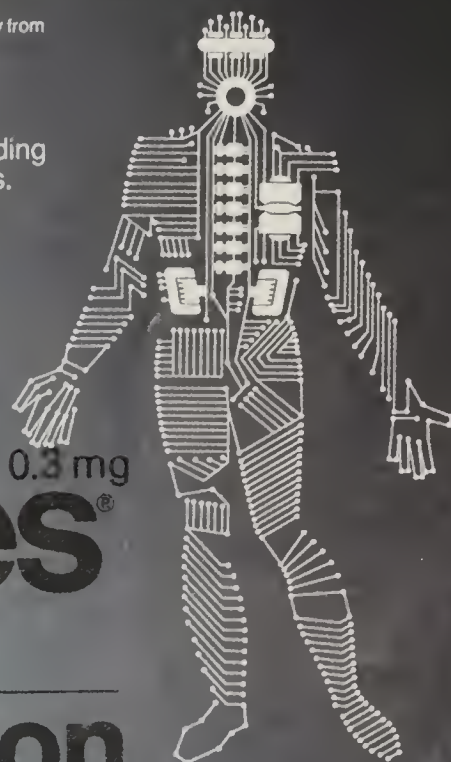
* Central alpha-adrenergic stimulation decreases sympathetic outflow from the brain as shown in animal studies.

† Data on file at Boehringer Ingelheim Ltd.

Please see last page for brief summary, including warnings, precautions, and adverse reactions.

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0.3 mg tablets**

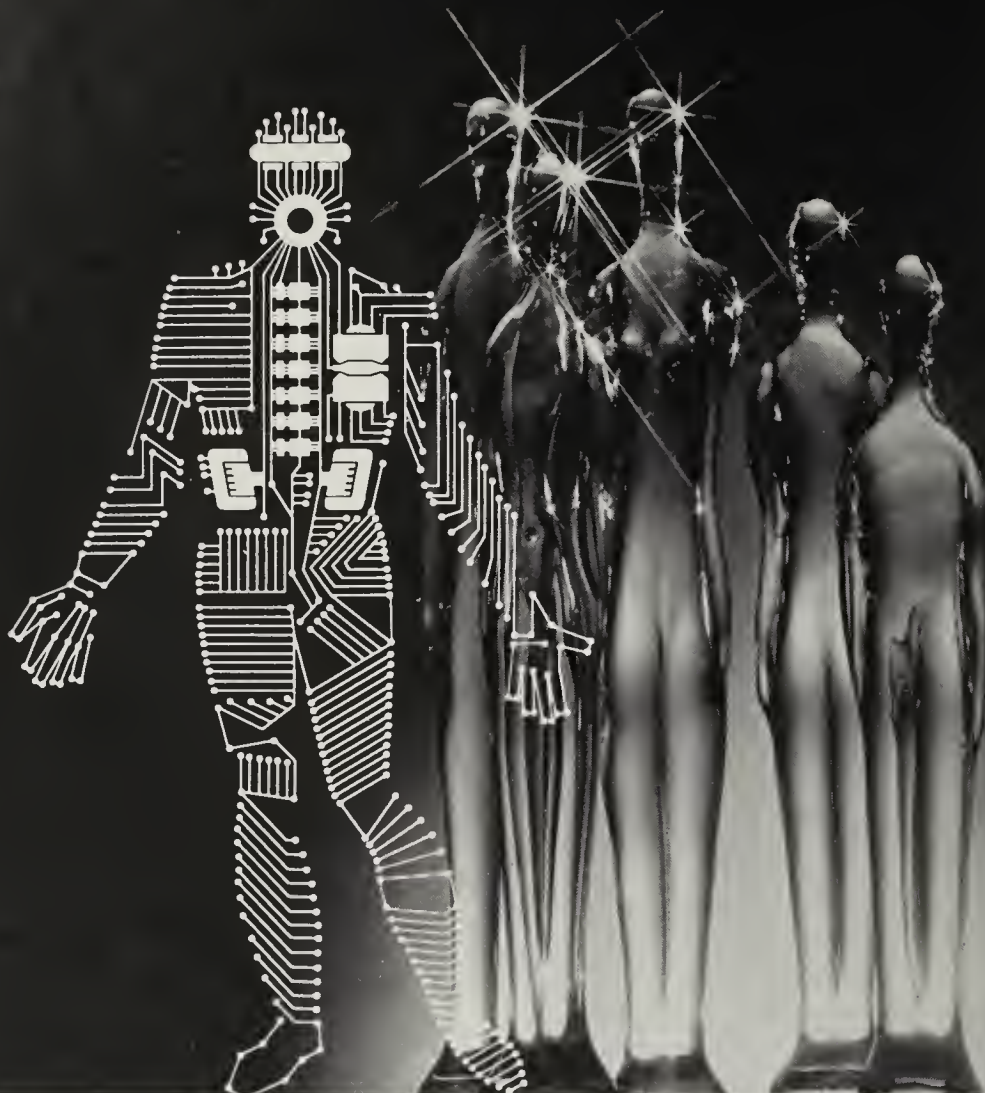
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Catapres®
(clonidine HCl)
Hypertension



α

The Alpha Advantage: It's for all kinds of hypertensives

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Catapres[®]
(clonidine HCl)
Hypertension



- No contraindications.
- Effective in all degrees of hypertension. It is mild to moderate in potency.
- Low incidence of depression, impotence, orthostatic hypotension—no fatal hepatotoxicity.
- Preserves kidney blood flow.

Most common side effects are dry mouth, drowsiness, and sedation which generally tend to diminish with time.

The usual starting dose of Catapres is 0.1 mg at breakfast and 0.1 mg at bedtime. Some patients may benefit from a starting dose of 0.1 mg at bedtime.

Usual daily dose range—0.2—0.8 mg

Maximum daily dose—2.4 mg
Doses as high as this have rarely been employed.

For optimal results, the dose of Catapres must be adjusted according to the patient's individual blood pressure response.

Catapres[®]
(clonidine hydrochloride)
Tablets of 0.1, 0.2, 0.3 mg

Indication: The drug is indicated in the treatment of hypertension. As an anti-hypertensive drug, Catapres (clonidine hydrochloride) is mild to moderate in potency. It may be employed in a general treatment program with a diuretic and/or other antihypertensive agents as needed for proper patient response.

Warnings: Tolerance may develop in some patients necessitating a reevaluation of therapy.

Usage in Pregnancy: In view of embryotoxic findings in animals, and since information on possible adverse effects in pregnant women is limited to uncontrolled clinical data, the drug is not recommended in women who are or may become pregnant unless the potential benefits outweigh the potential risk to mother and fetus.

Usage in Children: No clinical experience is available with the use of Catapres (clonidine hydrochloride) in children.

Precautions: When discontinuing Catapres (clonidine hydrochloride), reduce the dose gradually over 2 to 4 days to avoid a possible rapid rise in blood pressure and associated subjective symptoms such as nervousness, agitation, and headache. Patients should be instructed not to discontinue therapy without consulting their physician. Rare instances of hypertensive encephalopathy and death have been recorded after cessation of clonidine hydrochloride therapy. A causal relationship has not been established in these cases. It has been demonstrated that an excessive rise in blood pressure, should it occur, can be reversed by resumption of clonidine hydrochloride therapy or by intravenous phentolamine. Patients who engage in potentially hazardous activities, such as operating machinery or driving, should be advised of the sedative effect. This drug may enhance the CNS-depressive effects of alcohol, barbiturates and other sedatives. Like any other agent lowering blood pressure, clonidine hydrochloride should be used with caution in patients with severe coronary insufficiency, recent myocardial infarction, cerebrovascular disease or chronic renal failure.

As an integral part of their overall long-term care, patients treated with Catapres (clonidine hydrochloride) should receive periodic eye examinations. While, except for some dryness of the eyes, no drug-related abnormal ophthalmologic findings have been recorded with Catapres (clonidine hydrochloride), in several studies the drug produced a dose-dependent increase in the incidence and severity of

spontaneously occurring retinal degeneration in albino rats treated for 6 months or longer.

Adverse Reactions: The most common reactions are dry mouth, drowsiness and sedation. Constipation, dizziness, headache, and fatigue have been reported. Generally these effects tend to diminish with continued therapy. The following reactions have been associated with the drug, some of them rarely. (In some instances an exact causal relationship has not been established.) These include: Anorexia, malaise, nausea, vomiting, parotid pain, mild transient abnormalities in liver function tests; one report of possible drug-induced hepatitis without icterus and hyperbilirubinemia in a patient receiving clonidine hydrochloride, chloralhydrate and papaverine hydrochloride. Weight gain, transient elevation of blood glucose, or serum creatine phosphokinase: congestive heart failure, Raynaud's phenomenon; vivid dreams or nightmares, insomnia, other behavioral changes, nervousness, restlessness, anxiety and mental depression. Also rash, angioneurotic edema, hives, urticaria, thinning of the hair, pruritus not associated with a rash, impotence, urinary retention, increased sensitivity to alcohol, dryness, itching or burning of the eyes, dryness of the nasal mucosa, pallor, gynecomastia, weakly positive Coombs' test, asymptomatic electrocardiographic abnormalities manifested as Wenckebach period or ventricular trigeminy.

Overdosage: Profound hypotension, weakness, somnolence, diminished or absent reflexes and vomiting followed the accidental ingestion of Catapres (clonidine hydrochloride) by several children from 19 months to 5 years of age. Gastric lavage and administration of an analeptic and vasopressor led to complete recovery within 24 hours. Tolazoline in intravenous doses of 10 mg at 30-minute intervals usually abolishes all effects of Catapres, (clonidine hydrochloride) overdosage.

How Supplied: Catapres, brand of clonidine hydrochloride, is available as 0.1 mg (tan) and 0.2 mg (orange) oval, single-scored tablets in bottles of 100 and 1000. Also available as 0.3 mg (peach) oval, single-scored tablets in bottles of 100.

For complete details, please see full prescribing information.

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INDOCHINESE/continued

be infected with an organism resistant to INH. Children too young to be assessed for alterations of visual acuity should receive INH, rifampin, and streptomycin. The dose of drugs for adults are INH, 300 mg daily; rifampin, 600 mg daily (450 mg daily for persons weighing less than 50 kg); ethambutol, 15-20 mg per kg body weight daily (the dose can be rounded off, e.g., 800 mg, 1000 mg, 1200 mg). For children the doses are INH, 10 mg per kg of body weight daily up to a maximum of 300 mg; rifampin, 10 to 20 mg per kg of body weight daily; ethambutol, 15 to 20 mg per kg of body weight daily; streptomycin, 20 mg per kg of body weight up to the maximum of 1 g daily. Class A tuberculosis cases other than those with positive bacteriology and/or cavitory lesions on chest X ray may be started on treatment at the discretion of the examining physician, or treatment may be deferred until arrival in the United States.

When drug-susceptibility results are available, treatment can be adjusted accordingly. However, it is important that the regimen always contain at least 2 drugs to which the organisms are known to be, or thought to be, susceptible. If cultures are negative, precluding drug-susceptibility testing, then INH, rifampin, and ethambutol should all be continued for the duration of therapy. Treatment should continue for a period of 12 months after sputum specimens are negative. For patients with negative bacteriology, the total period of treatment should be 12 months.

If treatment has been started abroad on a refugee with Class A tuberculosis, the refugee would have negative sputum smears before being permitted to travel. Upon arrival, treatment should be continued, but specimens should be obtained for attempted culture and drug-susceptibility tests. If the culture results are positive, proceed as above and adjust regimen, if necessary, according to the drug-susceptibility test results. If the cultures are negative, precluding drug-susceptibility testing, it is necessary to continue a regimen of INH, rifampin, and ethambutol for a period of 12 months after sputum specimens are negative.

Class B tuberculosis patients are a high-risk group and should be re-evaluated upon arrival in the United States. If "active" disease is found, indicating either incorrect classification or development of progressive disease after the initial medical examination, consider the person as a case of tuberculosis and treat as described above. If the Class B designation is correct, these refugees are candidates for preventive therapy with INH. Even though as many as 10 percent of Class B patients may be infected with a INH-resistant organism, it is not possible to identify these individuals. Therefore, it is recommended that INH be used for preventive therapy; if tuberculosis caused by INH-resistant organisms should develop later in any of these persons, it can be treated appropriately with other drugs at that time.

Preventive therapy is recommended for contacts of tuberculosis patients and other infected persons who may be identified. Since a positive reaction from BCG vaccination cannot be distinguished from natural infection, the tuberculin test should be interpreted without regard to BCG vaccination. INH is recommended unless the person is known to have been exposed to a source case with INH-resistant tubercle bacilli. In that situation, 1 of the following 3 alternative approaches may be selected: 1) treat with INH; 2) treat with rifampin (alone or in combination with INH or another drug); or 3) use no drugs for preventive treatment but assure close clinical follow-up and provide treatment with appropriate drugs if tuberculosis develops.

Depending upon the number of refugees in the community and the resources available, health departments will have varying degrees of difficulty in accommodating the increased case load presented by Indochinese refugees. The recommended priorities for tuberculosis control in Indochinese refugees are as follows: 1) evaluation, management, and contact investigation of Class A cases; 2) evaluation, management, and contact investigation (if indicated) of Class B cases; 3) tuberculin screening and preventive therapy programs for children, e.g., testing of all refugee children entering the community's school system; 4) evaluation and follow-up of the family and other close associates of children found to be infected; and 5) tuberculin screening and preventive therapy programs for adult refugees under 35 years of age. Screening programs are not recommended for older refugees because the vast majority would not be candidates for preventive therapy. (The exception would be those with abnormal chest X rays who have already been identified as Class B patients at the time of their arrival in the United States).

Although there is some risk of transmission of tuberculosis from refugees to the U.S. population, the current methods of detection and the use of appropriate containment procedures make the risks minimal. Efforts are being made to improve the medical evaluation of refugees overseas, including the interpretation of X rays and performance of laboratory bacteriologic procedures, and to assure that health departments are properly notified of the arrival of refugees who have tuberculosis.

SEVENTH REGIONAL CONGRESS OF THE INTERNATIONAL COLLEGE OF SURGEONS

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Look into many aspects of trauma, emergencies at MSMS Annual Scientific Meeting Nov. 18-19-20

Trauma from several aspects — poisonings as seen in the emergency room, injuries to soft tissues, to the thoracic and genito-urinary areas, care of the injured child and emergency psychiatric situations — will be the subject of several courses planned at the 1980 MSMS Annual Scientific Meeting.

The three-day Category I CME session is planned Nov. 18-19-20 at the Hyatt Regency Dearborn.

Why so many courses on injuries and emergency situations?

"Emergency situations and medical care are very topical," explains Samuel M. McMahon, MD, Lansing, chairman of the Annual Scientific Meeting. "There is a great deal of interest today in emergency problems.

"This growth of interest coincides with the growth of emergency medicine as a specialty," he points out.

Common sense

Three of the directors of trauma and emergency courses contacted this summer talked of how situations in their specialties can best be handled by a common-sense approach. Each of them wanted to help physicians avoid inappropriate care.

"Urological trauma is not uncommon, and much of its care can be handled by the primary care physician," said Gerald F. Conway, MD, Royal Oak, director for the course, "Injuries to the Genito-Urinary Tract."

Doctor Conway's course is scheduled from 1:30 to 5 p.m. Wednesday, Nov. 19. The course is sponsored by the Michigan Branch, American Urological Association.

Doctor Conway explains that his course subject was chosen because urological trauma can be found in all age groups and the primary care physician has to know how to recognize and manage the minor cases and when to refer the more complicated cases to the specialist.



The course will emphasize pediatric urological trauma and iatrogenic injuries, to appeal to pediatricians and surgeons, he continues.

"In the pediatric age group, urological trauma often involves congenital anomalies," he says. "So care is aimed at the underlying anomaly, as well as the effects of the trauma.

"When someone mentions toxicology," said Michael Clark, MD, course director, "Clinical Toxicology in the Emergency Department," "everyone immediately thinks antidote.

"But there are only five true antidotes to poisoning. Many physicians don't appreciate that if they just do the abc's — airway, breathing and circulation — they will do the most good. Their time is better spent just doing the basics than wasting time trying to find the antidote."

Doctor Clark's course is scheduled from 8:30 a.m. to noon Wednesday, Nov. 19 and is sponsored by the Michigan Chapter, American College of Emergency Physicians. It will cover the general principles of management of the poisoned patient.

"Some of the initial life-saving procedures required in childhood trauma are just common sense," said Arthur S. Besser, MD, Detroit, director, "Care of the Injured Child." "Physicians often don't recognize this and may do something inappropriate which leads to further complications."

Doctor Besser will present surgeons and an intensivist from the new Pediatric Intensive Care Unit at

Henry Ford Hospital as well as the author of the first textbook on pediatric trauma, Robert Toulekian, MD, chairman and professor of pediatric surgery at Yale University.

Doctor Besser's course will cover the newer techniques in childhood trauma, many of which "really can be taken care of in the smaller community hospitals," he says.

Course list

Other emergency and trauma courses planned for the Annual Scientific Meeting are:

"Emergency Psychiatry: Theory and Practice," 1:30 to 5 p.m. Tuesday, Nov. 18. Course director is Bonnie Fauman, MD, Henry Ford Hospital. Sponsor is the Michigan Psychiatric Society.

"Thoracic Trauma: Problems in Diagnosis, Early Management and Disposition," 8:30 a.m. to noon Wednesday, Nov. 19; Dennis P. Horan, MD, Henry Ford Hospital, course director; sponsored by HFH Division of Trauma and Emergency Surgery.

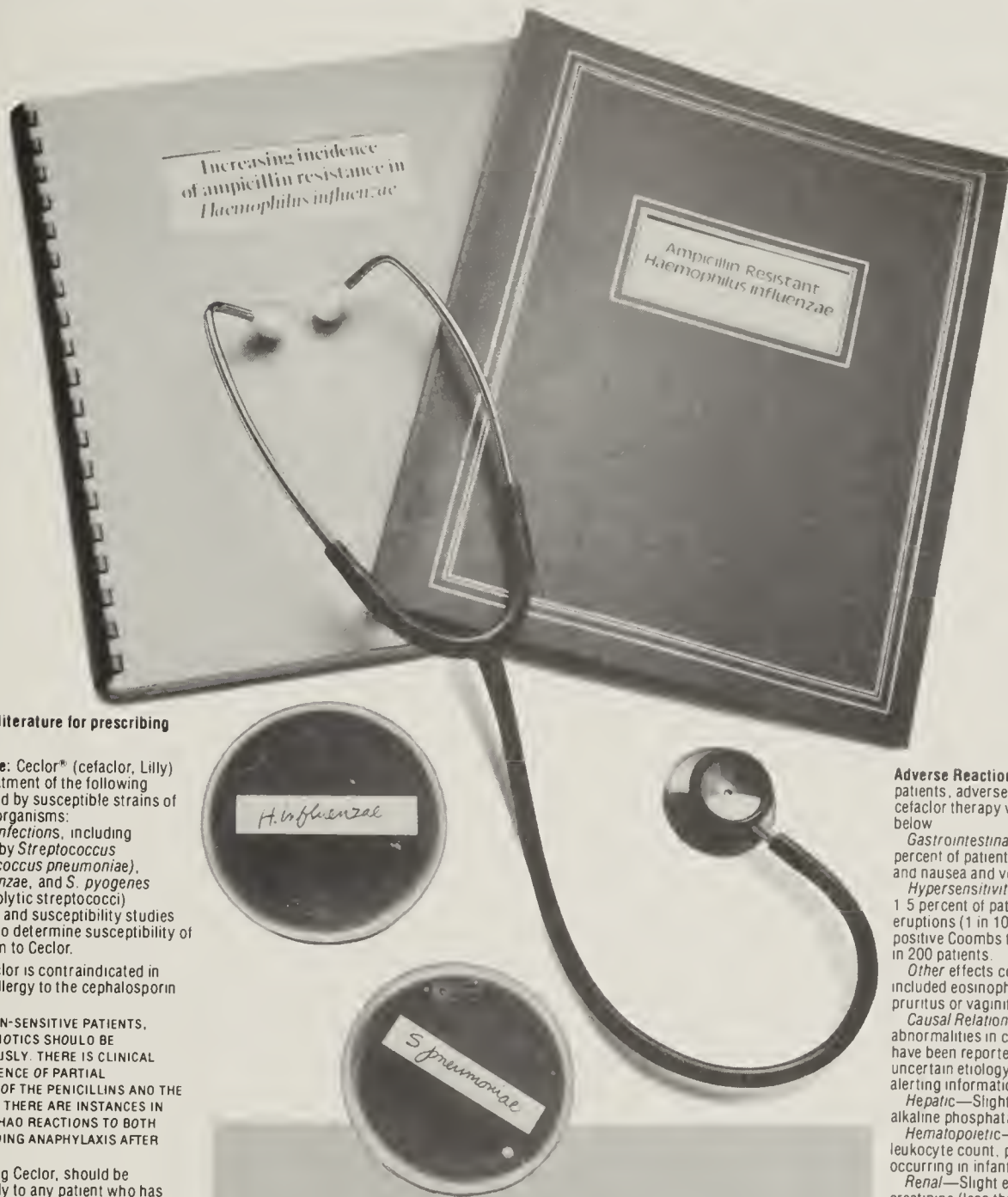
"Management of Difficult Soft Tissue Wounds," 1:30 p.m. to 5 p.m. Wednesday, Nov. 19; Errikos Constant, MD, Lansing, course director; sponsored by Michigan Academy of Plastic Surgeons.

A total of 54 Category I CME courses will be presented at the three-day MSMS program. Physicians who attend the courses may earn a maximum of 19 hours of credit.

The program annually draws approximately 2,000 physicians from around the state. Fees are \$5 per credit hour for MSMS members; \$10 per credit hour for non-members. Fee for residents will be \$5 per course. Registration forms will be published in the September and October issues of *Michigan Medicine* and the "Medigram" newsletter.

Further information is available from Sherry L. Fent at MSMS headquarters.

An added complication... in the treatment of bacterial bronchitis*



Brief Summary.
Consult the package literature for prescribing information.

Indications and Usage: Ceclor® (cefactor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms:

Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae* (*Diplococcus pneumoniae*), *Haemophilus influenzae*, and *S. pyogenes* (group A beta-hemolytic streptococci). Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Ceclor.

Contraindication: Ceclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS, AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS TO BOTH DRUG CLASSES (INCLUDING ANAPHYLAXIS AFTER PARENTERAL USE).

Antibiotics, including Ceclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

Precautions: If an allergic reaction to cefactor occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids.

Prolonged use of cefactor may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs test may be due to the drug.

Ceclor should be administered with caution in the presence of markedly impaired renal function. Under such a condition, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

Usage in Pregnancy—Although no teratogenic or antifertility effects were seen in reproduction studies in mice and rats receiving up to 12 times the maximum human dose or in ferrets given three times the maximum human dose, the safety of this drug for use in human pregnancy has not been established. The benefits of the drug in pregnant women should be weighed against a possible risk to the fetus.

Usage in Infancy—Safety of this product for use in infants less than one month of age has not been established.

Some ampicillin-resistant strains of *Haemophilus influenzae*—a recognized complication of bacterial bronchitis*—are sensitive to treatment with Ceclor.¹⁻⁶

In clinical trials, patients with bacterial bronchitis due to susceptible strains of *Streptococcus pneumoniae*, *H. influenzae*, *S. pyogenes* (group A beta-hemolytic streptococci), or multiple organisms achieved a satisfactory clinical response with Ceclor.⁷

Ceclor®

cefactor

Pulvules®, 250 and 500 mg

Adverse Reactions: In clinical studies in 1493 patients, adverse effects considered related to cefactor therapy were uncommon and are listed below.

Gastrointestinal symptoms occurred in about 2.5 percent of patients and included diarrhea (1 in 70) and nausea and vomiting (1 in 90).

Hypersensitivity reactions were reported in about 1.5 percent of patients and included morbilliform eruptions (1 in 100), pruritus, urticaria, and positive Coombs tests each occurred in less than 1 in 200 patients.

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

Causal Relationship Uncertain—Transitory abnormalities in clinical laboratory tests results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician.

Hepatic—Slight elevations in SGOT, SGPT, or alkaline phosphatase values (1 in 40).

Hematopoietic—Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40).

Renal—Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200).

[070379R]

*Many authorities attribute acute infectious exacerbation of chronic bronchitis to either *S. pneumoniae* or *H. influenzae*.

Note: Ceclor® (cefactor) is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

References

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3. Antimicrob. Agents Chemother., 13:584, 1978.
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7. Data on file, Eli Lilly and Company.
8. Principles and Practice of Infectious Diseases (edited by G. L. Mandell, R. G. Douglas, Jr., and J. E. Bennett), p. 487. New York: John Wiley & Sons, 1979.

Additional information available to the profession on request from Eli Lilly and Company, Indianapolis, Indiana 46285.
Eli Lilly Industries, Inc.
Carolina, Puerto Rico 00630



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MSMS Steering Committee informing MDs of health planning

By Bonnie L. Groff, MSMS staff



The moratorium on bed reduction, appropriateness review, EMS categorization, and State Health Plan II are all major concerns of the MSMS Health Planning Committee.

The Steering Committee hopes to increase physician awareness of health planning issues and to encourage physician involvement in the health planning process.

During the current moratorium on the bed reduction process, one of the committee's projects is working with the Special Joint Committee on Bed Reduction to restructure the Detroit area bed reduction plan into a more equitable vehicle.

In addition, the committee is carrying out resolution 19-80A, which was passed at the 1980 MSMS House of Delegates and calls for a study to be done on bed reduction.

The purpose of the study is to see if there are excess beds and whether their removal will save health care dollars. The findings of the study are scheduled to be presented at the mid-September meeting of the committee.

Steering Committee involvement in the area of appropriateness review includes reviewing criteria by which health care services are evaluated.

Appropriateness review is for critiquing existing services and facilities in contrast to the already-established certificate of need program which regulates the growth of new construction and services.

Another project of the MSMS Health Planning Steering Committee is the development of a new format for emergency medical services categorization.

The new format proposed by the committee has been submitted to the MSMS Council for approval.

Now that State Health Plan II has been passed by the Statewide Health Coordinating Council, the Steering Committee is preparing comments on the plan to submit to the legislature and the governor for consideration.

The plan calls for ultimate reduction of hospital beds to a ratio of 800 hospital days per 1,000 population. This goal is a decrease in hospital days as significant as that proposed by the Michigan Hospital Bed Reduction Program which attempts to reduce 1,200 hospital days per 1,000 population to 1,000 hospital days per 1,000 population.

In addition to these projects, the committee has been asked by John R. Ylvisaker, MD, MSMS president, to

compile a report on the National Health Planning and Resources Development Act. Focus of the report is to make suggestions as to how the law should be changed to gain greater effectiveness in the health planning process and where change is needed to permit more efficient health planning.

The Steering Committee is also working to ensure physicians are serving on the SHCC as well as on HSA boards and committees. This is crucial since the terms of office of several physicians will be ending this year.

Members of the MSMS Health Planning Steering Committee include: Kenneth J. Ray, MD, chairman, Trenton; Billy B. Baumann, MD, Pontiac; George R. Gerber, MD, Rochester; George H. Greidinger, MD, Flint; D. Bonta Hiscoe, MD, East Lansing; John P. Papp, MD, Grand Rapids; Richard J. Potter, MD, Negaunee; Charles L. Seifert, MD, Battle Creek; Robert J. Toteff, MD, Saginaw; Ian D. Wilson, MD, Petoskey; Roger W. Mecum, Detroit, advisor, and Hermann A. Ziel, MD, Lansing, consultant.



"Take it easy for a few days."

DESCRIPTION: Methyltestosterone is 17 β -Hydroxy-17-Methylandro-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunichism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-puberal cryptorchidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric,

avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE**

REACTIONS: Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. In the male: Eunuchoidism and eunichism, 10 to 40 mg. Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg. Postpuberal cryptorchism, 30 mg. **REFERENCE:** R. B. Greenblatt, M.D.; R. Witherington, M.D.; I. B. Sipahoglu, M.D., Hormones for Improved Sexuality in the Male and the Female Climacteric, *Drug Therapy*, Sept. 1976. **SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only.

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Working for new U-M hospital teaches dean need for MD-input

By Shelton Reece, special to Michigan Medicine

"After many a summer," it appears a new University of Michigan Hospital complex will become a reality within the decade.

The University now has certificates of need, State Department of Health, and Comprehensive Health Planning Council of Southeastern Michigan approvals to build what probably will be the most expensive hospital complex in the nation's history. The project is budgeted at \$210 million with a ceiling of 15 percent for cost overruns.

Bold in scope, the project will be completed sometime in 1986 on what is called "the North Site," in the heart of the University's campus, on land presently occupied by the North Outpatient Clinic Building.

The project calls for a new 586-bed structure to replace the "Old Main" adult medical-surgical building as well as its Adult Psychiatric Hospital (formerly the Neuropsychiatric Institute).

The structure also will replace the Clinical Faculty Office and North Outpatient Buildings, which will be demolished. The Outpatient Building will be converted into offices for faculty and staff.

As a part of the project, Mott, Women's and Holden Hospital buildings will be renovated and will provide another 241 beds. New eye and burn centers will be created through renovation and new construction, and will add another 61 beds. The total number of beds meets the 888-bed limit set by the state for new and renovated units combined. Currently, the hospital has 965 licensed beds.

Dream culminated

When construction commences, an old dream of the University's will be culminated. That dream is to revitalize facilities needed to care for acutely ill patients from the region, invigorate research projects, and educate 1,100 medical students plus 3,000 nursing and allied health care students per year.

Originally, the University planned to construct a \$311 million hospital. The size and cost was reduced due to much publicized opposition from the CHPC, some segments of Michigan business, and labor.

According to John A. Gronvall, MD, dean of the U of M Medical School, groundbreaking probably will be held during the fall of 1982.

"At this point (early May), Dean Gronvall commented, "we do not have final financial details worked out. In other words, we do not know exactly what share of the costs the state will pay and what share will be the responsibility of the university. That decision is, of course, one that the state legislature will make.

"We do, however, have necessary approvals for the project and Albert Kahn Associates, Inc. is proceeding with architectural planning.

"We are working on what is called the 'block plan,' whereby the needs of each department are worked out and a block of space is designated for each. Finally, each block is put together and we see how the total building will look.

As it looks now, says Dean Gronvall, the old hospital building will be demolished, except possibly for the lower floors, after the new hospital is occupied.

During construction, the old St. Joseph's Hospital building will be used for administration and support unit offices as well as for storage. Upon completion of the new hospital, St. Joseph's will become a university building to be used for other university purposes.

Tertiary emphasis

Dean Gronvall stated that while the range of services at the new hospital will be much the same as they are now, the hospital will concentrate more on referral and tertiary practice and less on primary and secondary care.

"Completion of the new hospital will not directly affect our capability to educate medical students. We long

ago exceeded the capacity of the University Hospital. We now have, and plan to keep, students working in the Veteran's, St. Joseph's, Wayne County General, and Henry Ford hospitals.

"We realize there is a great deal of concern about the cost of health care in general, and about the cost of this project. We share those concerns. However, the University feels that the people of the State of Michigan should have the best health care available.

"We definitely have a critical role in helping to provide that care. We often function as a hospital of last resort, or one to which patients are referred after they have been treated elsewhere.

"Additionally, the University has a vital responsibility to provide well-trained physicians for the coming generations, and to carry on our research activities.

"The old hospital has gradually been growing more and more obsolete. To accomplish our purposes, we have to have the new one. It is expensive, yes, but we are certain that the investment will prove to be very sound and forward-looking."

MDs' contributions

The dean says that among the things he has learned from the many events that have occurred during negotiations for the new hospital is that physicians, as members of hospital medical staffs, would be well advised to be active participants in health planning systems.

"Such participation would help us to better understand the basis on which agencies review projects," he says.

"We need to work with the agencies, to be involved, and by our active participation, help arrive at decisions that are the most practical for all concerned."



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Health of rural, elderly, and children target of new Health Council grant



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The W. K. Kellogg Foundation has approved a three-year grant of \$314,500 to the Michigan Health Council (MHC) to stimulate development, cooperation and involvement among its more than 150 members and affiliated agencies, associations and institutions in health promotion activities.

A wide range of activities will be carried out by the Michigan Health Council to emphasize the importance of making behavioral and environmental changes conducive to good health.

The Health Council is a non-governmental, non-profit, voluntary health education organization operating since 1943 from its headquarters in East Lansing. MSMS was instrumental in its founding.

MHC is the first statewide organization in the nation to undertake such a comprehensive health promotion commitment, according to the Kellogg Foundation. MHC will develop an inventory of health promotion activities and materials and will encourage their use by other organizations. MHC task forces will teach

wise health habits through community organizations and agencies and will offer leadership workshops.

Specific attention in this health awareness project will be given by MHC to the needs of the elderly, the rural resident, and school-age youngsters. MHC will foster more comprehensive health education in Michigan schools.

In accepting the three-year grant, MHC President Robert Tupper, MD, Grand Rapids, explained, "Our broad-based health awareness program will inform and challenge all residents of our state, and especially school children, the elderly and rural residents."

The MHC president declared "the new rhetoric of health awareness must be validated by individual commitment. That hoped-for movement in Michigan will be led by MHC working with and through its 152 member organizations, affiliates, volunteers, skilled staff members and the thousands of young people today preparing for health careers."

"MHC hopes to be able to capitalize on the major shift in recent

years in the American value system toward enhancing the individual's physical and mental health," states Doctor Tupper. "Voluntary cooperation will improve scheduling and public information, and also will provide a more forceful challenge to Michigan residents to change to more healthful practices."

In explaining the five-pronged project, Herbert A. Auer, MHC executive vice president, reports that:

1. MHC will strive to bring together health groups to build a new spirit of cooperation. All interested associations, agencies, institutions and firms will be invited to share in the planning and the expansion of Health Promotion activities. MHC wants to play a facilitating role in this voluntary effort.

2. MHC will initiate some new activities in health promotion to reach Michigan residents as individuals. MHC will not duplicate existing programs but will pilot test some different approaches — most likely to reach the worker.

3. MHC will work with and through the Michigan School Health Association to expand comprehensive school health. The Michigan Department of Education, the Michigan Department of Public Health and the Michigan Association of School Boards have indicated a willingness to assist. Many MHC member organizations already provide curriculum materials and speakers to assist teachers and school systems.

4. MHC will involve others in a cooperative effort to increase health education and health awareness among the elderly. The needs of growing numbers of senior citizens have been recognized but diverse resources and creative programs are needed. MHC will appeal to all health groups, government and colleges to begin some pilot programs.

5. MHC will continue to develop health promotion in rural Michigan through its Committee on Rural Health which already includes eight different health and rural organizations. MHC has developed a strong foundation and has explored many ideas through a 1977-79 three-year rural health grant from two Michigan foundations.

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EQUAGESIC—Abbreviated Summary

***INDICATIONS:** Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:

"Possibly" effective: for the treatment of pain accompanied by tension and/or anxiety in patients with musculoskeletal disease or tension headache. Final classification of the less-than-effective indications requires further investigation.

The effectiveness of Equagesic in long-term use, i.e. more than four months, has not been assessed by systematic clinical studies. The physician should periodically reassess usefulness of the drug for the individual patient.

CONTRAINDICATIONS: Equagesic should not be given to individuals with a history of sensitivity or severe intolerance to aspirin, meprobamate, or ethoheptazine citrate.

WARNINGS: Careful supervision of dose and amounts prescribed for patients is advised, especially with those patients with known propensity for taking excessive quantities of drugs. Excessive and prolonged use in susceptible persons, e.g., alcoholics, former addicts, and other severe psychoneurotics, has been reported to result in dependence on or habituation to the drug. Where excessive dosage has continued for weeks or months, dosage should be reduced gradually rather than abruptly stopped since withdrawal of a "crutch" may precipitate withdrawal reaction of greater proportions than that for which the drug was originally prescribed. Abrupt discontinuance of doses in excess of the recommended dose has resulted in some cases in the occurrence of epileptiform seizures.

Special care should be taken to warn patients taking meprobamate that tolerance to alcohol may be lowered with resultant slowing of reaction time and impairment of judgement and coordination.

USAGE IN PREGNANCY AND LACTATION: An increased risk of congenital malformations associated with the use of minor tranquilizers (meprobamate, chlorthalidone,

azepoxide, and diazepam) during the first trimester of pregnancy has been suggested in several studies. Because use of these drugs is rarely a matter of urgency, their use during this period should almost always be avoided. The possibility that a woman of child-bearing potential may be pregnant at the time of institution of therapy should be considered. Patients should be advised that if they become pregnant during therapy or intend to become pregnant they should communicate with their physicians about the desirability of discontinuing the drug.

Meprobamate passes the placental barrier. It is present both in umbilical-cord blood at or near maternal plasma levels and in breast milk of lactating mothers at concentrations two to four times that of maternal plasma. When use of meprobamate is contemplated in breast-feeding patients, the drug's higher concentrations in breast milk as compared to maternal plasma levels should be considered.

Preparations containing aspirin should be kept out of the reach of children. Equagesic is not recommended for patients 12 years of age and under.

PRECAUTIONS: Should drowsiness, ataxia, or visual disturbance occur, the dose should be reduced. If symptoms continue, patients should not operate a motor vehicle or any dangerous machinery.

Suicidal attempts with meprobamate have resulted in coma, shock, vasomotor and respiratory collapse, and anuria. Very few suicidal attempts were fatal, although some patients ingested very large amounts of the drug (20 to 40 gm). These doses are much greater than recommended. The drug should be given cautiously, and in small amounts, to patients who have suicidal tendencies. In cases where excessive doses have been taken, sleep ensues rapidly and blood pressure, pulse, and respiratory rates are reduced to basal levels. Hyperventilation has been reported occasionally. Any drug remaining in the stomach should be removed and symptomatic treatment given. Should respiration become very shallow and slow, CNS stimulants, e.g., caffeine, Metrazol, or am-

phetamine, may be cautiously administered. If severe hypotension develops, pressor amines should be used parenterally to restore blood pressure to normal levels.

ADVERSE REACTIONS: A small percentage of patients may experience nausea with or without vomiting and epigastric distress. Dizziness occurs rarely when meprobamate and ethoheptazine citrate with aspirin is administered in recommended dosage. The meprobamate may cause drowsiness but as a rule, this disappears as therapy is continued. Should drowsiness persist and be associated with ataxia, this symptom can usually be controlled by decreasing the dose, but occasionally it may be desirable to administer central stimulants such as amphetamine or mephentermine sulfate concomitantly to control drowsiness.

A clearly related side effect to the administration of meprobamate is the rare occurrence of allergic or idiosyncratic reactions. This response develops as a rule, in patients who have had only 1-4 doses of meprobamate and have not had a previous contact with the drug. Previous history of allergy may or may not be related to the incidence of reactions.

Mild reactions are characterized by an itchy urticarial or erythematous, maculopapular rash which may be generalized or confined to the groin. Acute nonthrombocytopenic purpura with cutaneous petechiae, ecchymoses, peripheral edema, and fever have also been reported.

More severe cases, observed only very rarely, may also have other allergic responses, including fever, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anaphylaxis, stomatitis and proctitis (1 case), and hyperthermia. Treatment should be symptomatic such as administration of epinephrine, antihistamine, and possibly hydrocortisone. Meprobamate should be stopped, and re-institution of therapy should not be attempted.

Rare cases have been reported where patients receiving meprobamate suffered from aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis, and hemolytic anemia. In nearly every instance reported, other toxic agents known to have caused these conditions have been associated with meprobamate. A few cases of leukopenia during

continuous administration of meprobamate are reported, most of these returned to normal without discontinuation of the drug.

Impairment of accommodation and visual acuity has been reported rarely.

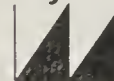
OVERDOSE: Two instances of accidental or intentional significant overdosage with ethoheptazine citrate combined with aspirin have been reported. These were accompanied by symptoms of CNS depression, including drowsiness and light-headedness with uneventful recovery. However, on the basis of pharmacological data, it may be anticipated that CNS stimulation could occur. Other anticipated symptoms would include nausea and vomiting. Appropriate therapy of signs and symptoms as they appear is the only recommendation possible at this time. Overdosage with ethoheptazine combined with aspirin would probably produce the usual symptoms and signs of salicylate intoxication. Observation and treatment should include induced vomiting or gastric lavage, specific parenteral electrolyte therapy for ketoacidosis and dehydration, watching for evidence of hemorrhagic manifestations due to hypoprothrombinemia which if it occurs, usually requires whole-blood transfusions.

DESCRIPTION: Each Equagesic tablet contains 150 mg meprobamate, 75 mg ethoheptazine citrate and 250 mg aspirin.

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*This drug has been evaluated as possibly effective for this indication.

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WYGESIC—Abbreviated Summary

INDICATION: For the relief of mild-to-moderate pain.
CONTRAINDICATION: Hypersensitivity to propoxyphene or to acetaminophen.

WARNINGS: CNS ADDITIVE EFFECTS AND OVERDOSAGE. Propoxyphene in combination with alcohol, tranquilizers, sedative-hypnotics, or other CNS depressants has an additive depressant effect. Patients taking this drug should be advised of the additive effect and warned not to exceed the dosage recommended. Toxic effects and fatalities have occurred following overdoses of propoxyphene alone or in combination with other CNS depressants. Most of these patients had histories of emotional disturbances or suicidal ideation or attempts, as well as misuse of tranquilizers, alcohol, or other CNS-active drugs. Caution should be exercised in prescribing large amounts of propoxyphene for such patients (see Management of Overdosage).

DRUG DEPENDENCE: Propoxyphene can produce drug dependence characterized by psychic dependence and less frequently, physical dependence and tolerance. It will only partially suppress the withdrawal syndrome in individuals physically dependent on morphine or other narcotics. The abuse liability of propoxyphene is qualitatively similar to codeine's although quantitatively less, and propoxyphene should be prescribed with the same degree of caution appropriate to the use of codeine.

USAGE IN AMBULATORY PATIENTS: Propoxyphene may impair the mental and/or physical abilities required for potentially hazardous tasks, e.g. driving a car or operating machinery. Patients should be cautioned accordingly.

USAGE IN PREGNANCY: Safe use in pregnancy has not been established relative to possible adverse effects on fetal development. **INSTANCES OF WITHDRAWAL SYMPTOMS IN THE NEONATE HAVE BEEN REPORTED FOLLOWING USAGE DURING PREGNANCY.** Therefore, propoxyphene should not be used in pregnant women unless, in the

judgement of the physician, the potential benefits outweigh the possible hazards.

USAGE IN CHILDREN: Propoxyphene is not recommended for children because documented clinical experience has been insufficient to establish safety and a suitable dosage regimen in the pediatric group.

PRECAUTIONS: Confusion, anxiety, and tremors have been reported in a few patients receiving propoxyphene concomitantly with orphenadrine. The CNS depressant effect of propoxyphene may be additive with other CNS depressants, including alcohol.

ADVERSE REACTIONS: The most frequent adverse reactions are dizziness, sedation, nausea, and vomiting. These seem more prominent in ambulatory than in nonambulatory patients; some of these reactions may be alleviated if the patient lies down. Other adverse reactions include constipation, abdominal pain, skin rashes, light-headedness, headache, weakness, euphoria, dysphoria, and minor visual disturbances. The chronic ingestion of propoxyphene in doses over 800 mg per day has caused toxic psychoses and convulsions. Cases of liver dysfunction have been reported.

DRUG INTERACTIONS: Propoxyphene in combination with alcohol, tranquilizers, sedative-hypnotics, and other CNS depressants has an additive depressant effect. Patients taking this drug should be advised of the additive effect and warned not to exceed the dosage recommended. (see Warnings.) Confusion, anxiety, and tremors have been reported in a few patients receiving propoxyphene concomitantly with orphenadrine.

MANAGEMENT OF OVERDOSAGE: SYMPTOMS The manifestations of serious overdosage with propoxyphene are similar to those of narcotic overdosage and include respiratory depression (a decrease in respiratory rate and/or tidal volume, Cheyne-Stokes respiration, cyanosis), extreme somnolence progressing to stupor or coma, pupillary constriction, and circulatory collapse. In addition to these characteristics, which are reversed by narcotic antago-

nists such as naloxone, there may be other effects. Overdoses of propoxyphene can cause delay of cardiac conduction as well as focal or generalized convulsions, a prominent feature in most cases of severe poisoning. Cardiac arrhythmias and pulmonary edema have occasionally been reported, and apnea, cardiac arrest, and death have occurred.

Symptoms of massive overdosage with acetaminophen may include nausea, vomiting, anorexia, and abdominal pain, beginning shortly after ingestion and lasting for 12 to 24 hours. However, early recognition may be difficult since early symptoms may be mild and nonspecific. Evidence of liver damage is usually delayed. After the initial symptoms, the patient may feel less ill, however, laboratory determinations are likely to show a rapid rise in liver enzymes and bilirubin. In case of serious hepatotoxicity, jaundice, coagulation defects, hypoglycemia, encephalopathy, coma, and death may follow. Renal failure due to tubular necrosis, and myocardiopathy, have also been reported.

Ingestion of 10 grams or more of acetaminophen may produce hepatotoxicity. A 13-gram dose has reportedly been fatal.

TREATMENT: Primary attention should be given to the reestablishment of adequate respiratory exchange through provision of a patent airway and institution of assisted or controlled ventilation. The narcotic antagonists, naloxone, nalorphine, and levallorphan, are specific antidotes against the respiratory depression produced by propoxyphene. An appropriate dose of one of these antagonists should be administered, preferably IV, simultaneously with efforts at respiratory resuscitation and the antagonist should be repeated as necessary until the patient's condition remains satisfactory. In addition to a narcotic antagonist, the patient may require careful titration with an anticonvulsant to control seizures. Analeptic drugs (e.g. caffeine or amphetamine) should not be used because of their tendency to precipitate convulsions.

Oxygen, IV fluids, vasopressors and other supportive measures should be used as indicated. Gastric lavage may be helpful. Activated charcoal can absorb a significant amount of ingested propoxyphene. Dialysis is of little value in poisoning by propoxyphene alone. Acetaminophen is rapidly absorbed, and efforts to remove the drug from the body should not be delayed. Copious gastric lavage and/or induction of emesis may be indicated. Activated charcoal is probably ineffective unless administered almost immediately after acetaminophen ingestion. Neither forced diuresis nor hemodialysis appears to be effective in removing acetaminophen. Since acetaminophen in overdose may have an antidiuretic effect and may produce renal damage, administration of fluids should be carefully monitored to avoid overload. It has been reported that mercaptamine (cysteine) or other thiol compounds may protect against liver damage if given soon after overdosage (8-10 hours). N-acetylcysteine is under investigation as a less toxic alternative to mercaptamine, which may cause anorexia, nausea, vomiting, and drowsiness. Appropriate literature should be consulted for further information. (JAMA 237:2406-2407, 1977)

Clinical and laboratory evidence of hepatotoxicity may be delayed up to one week. Acetaminophen plasma levels and half-life may be useful in assessing the likelihood of hepatotoxicity. Serial hepatic enzyme determinations are also recommended.

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MEETINGS



MSMS, MSMS/A, AMA, and medical assistants

Aug. 27-Sept. 4 — MSMS/Intrav Swiss Adventure, contact: Marcelyn Ireland, MSMS headquarters.

Sept. 10 — MSMS Council, MSMS headquarters, contact: Warren Tryloff, MSMS headquarters.

Sept. 10-29 — MSMS/Intrav China Adventure, contact: Marcelyn Ireland, MSMS headquarters.

Sept. 11-12 — AMA 40th Annual Congress of Occupational Health, Salt Lake City, contact: Department of Environmental, Public and Occupational Health, AMA, 535 N. Dearborn, Chicago, 60610.

Sept. 27-29 — AMA meeting, "Drugs in Medical Practice," Crown Center Hotel, Kansas City, contact: Department of Scientific Assembly, AMA, 535 N. Dearborn St., Chicago, 60610.

Oct. 15 — AMA meeting, "Newer Clinical Approaches to Sexually Transmissible Diseases," contact: Department of Environmental, Public and Occupational Health, AMA, 535 N. Dearborn St., Chicago, 60610.

Oct. 17-28 — MSMS/Intrav Western Mediterranean Air/Sea Cruise, contact: Marcelyn Ireland, MSMS headquarters, 517/337-1351.

Oct. 22 — MSMS Council, MSMS headquarters, contact: Warren Tryloff, MSMS headquarters.

Oct. 24-25 — AMA Fourth National Conference on Medical Care and Health Services in Correctional Institutions, Chicago, contact: AMA Correctional Programs, 535 N. Dearborn St., Chicago, 60610.

Oct. 29-Nov. 1 — AMA Fourth National Conference on the Impaired Physician, Baltimore, MD, contact: Department of Mental Health, AMA, 535 N. Dearborn, Chicago, 60610.

Nov. 18-20 — MSMS Annual Scientific Meeting, Hyatt Regency Dearborn, contact: Sherry Fent, MSMS headquarters.

Dec. 3 — MSMS Council, MSMS headquarters, contact: Warren Tryloff, MSMS headquarters.

Other meetings

Aug. 22-24 — 21st Congress of the Professions, Boyne Highlands, contact: Michigan Association of the Professions, 1407 S. Harrison Rd., P.O. Box 946, East Lansing, 48823, 517/337-1725.

Sept. 3 — Board Meeting, Michigan Chapter, American College of Emergency Physicians, MSMS headquarters, contact: Michigan Chapter, ACEP, P.O. Box 1611, East Lansing, 48823, 517/332-6500.

Sept. 25-27 — 1980 Walter P. Work Society, Stanford Court Hotel, San Francisco, contact: Nels R. Olson, MD, Box 61, University Hospital, Ann Arbor, 48109.

Oct. 25-30 — Annual Meeting, American Academy of Pediatrics, Detroit, contact: Robert S. Holm, MD, Southwestern Michigan Area Health Education Center, 252 E. Lovell St., Kalamazoo, 49007, 616/383-6360.

Nov. 5 — Board meeting, Michigan Chapter, American College of Emergency Physicians, MSMS headquarters, contact: Michigan Chapter, ACEP, P.O. Box 1611, East Lansing, 48823, 517/332-6500.

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CATEGORY I COURSES

Michigan Medicine each month carries a list of opportunities in Michigan for doctors of medicine to obtain Category I credit toward meeting the requirements of Michigan law. Sponsors of Category I programs and courses in Michigan are invited to submit information for the monthly calendar.

Each listing below, of programs that carry at least 3 hours of Category I credit, indicates a contact person, so the physician can obtain details. Physicians with questions about accredited programs may phone MSMS Headquarters, 517/337-1351.

Date: Aug. 22-25, 6th Annual Mackinac Island Conference. **Location:** Grand Hotel, Mackinac Island. **Sponsor:** U-M Office of Continuing Medical Education. **For:** All interested physicians. **Cost:** \$150. **Contact:** Towsley Center for CME, 313/764-2287. **Approved for:** 11 hours of Category I Credit.

Date: Aug. 23-24, Anatomy and Techniques of Regional Anesthesia. **Location:** Wayne State University School of Medicine, Scott Hall, Detroit. **Sponsor:** Wayne State University. **For:** All interested physicians. **Contact:** Wayne State University School of Medicine, Division of Continuing Medical Education, 9B-32 Health Care Institute, Detroit, 48201. **Approved for:** 12 hours of Category I Credit.

Date: Sept. 11-14, Upper Peninsula Medical Society Meeting. **Location:** Mackinac Island. **Sponsor:** Upper Peninsula Medical Society. **For:** All interested physicians. **Cost:** \$125. **Contact:** Frederick E. Ludwig, MD, 906/265-5101. **Approved for:** 17 hours of Category I Credit.

Date: Sept. 13, The Practical Application of Electron Microscopy to Surgical Pathology. **Location:** Munson Medical Center, Traverse City. **Sponsor:** Michigan Society of Pathologists. **For:**

Pathologists. **Contact:** T. A. Reyman, MD, Department of Pathology, Mt. Carmel Mercy Hospital, Detroit, 48235. **Approved for:** 3 hours of Category I Credit.

Date: Sept. 17, A Day On Cardiac Pacing. **Location:** Michigan Inn, Southfield. **Sponsor:** Henry Ford Hospital. **For:** All interested physicians. **Cost:** \$40. **Contact:** Medical Education, Henry Ford Hospital, 2799 W. Grand Blvd., Detroit, 48202 313/876-1464. **Approved for:** 5 hours of Category I Credit.

Date: Sept. 24, Renal Problems for the Practicing Physician. **Location:** Kalamazoo Center, Kalamazoo. **Sponsor:** Michigan Nephrology Center. **Co-Sponsor:** Southwestern Michigan Area Health Education Center. **For:** All primary care physicians. **Cost:** \$40. **Contact:** Charles L. Zeller, Jr., MD, Continuing Medical Education, 252 East Lovell, Room 364, Kalamazoo, 49007. **Approved for:** 7 hours of Category I Credit.

Date: Sept. 24-25, 1980 Western Michigan Trauma Symposium. **Location:** East Auditorium, Butterworth Hospital, Grand Rapids. **Sponsor:** Greater Grand Rapids Area, American Association of Critical Care Nurses. **For:** All interested medical and paramedical personnel. **Cost:** \$15

per day. **Contact:** Beth DeVriendt, Butterworth Hospital, 100 Michigan St., NE. Grand Rapids, 49503 (616/774-1405). **Approved for:** 15 hours of Category I Credit.

Date: Sept. 25-26, Nitrosoureas: Current Status and New Developments. **Location:** Hyatt Regency Dearborn. **Sponsor:** Wayne State University School of Medicine Department of Oncology, Harper-Grace Hospitals and the Comprehensive Cancer Center of Metropolitan Detroit and Bristol Laboratories. **For:** All interested physicians. **Contact:** David Moss, Symposium Coordinator, Bristol Laboratories, P.O. Box 657, Syracuse, NY 13201. **Approved for:** 12 hours of Category I Credit.

Date: Sept. 25-27, Electrophysiology of Cardiac Arrhythmias and Conduction Defects. **Location:** Detroit Plaza Hotel. **Sponsor:** Michigan Heart Association and Council on Clinical Cardiology of the American Heart Association. **For:** All interested physicians. **Contact:** Eleanor D. Peterson, RN, Michigan Heart Association, P.O. Box LV 160, Southfield, 48076. 313/557-9500. **Approved for:** 16½ hours of Category I Credit.

Date: Sept. 27, What's New in the Chest. **Location:** Education and Research Center, Henry Ford Hospital. **Sponsor:** Henry Ford Hospital. **For:** All interested physicians. **Contact:** Medical Education, Henry Ford Hospital, 2799 W. Grand Blvd., Detroit, 48202 313/876-1464. **Approved for:** 7 hours of Category I Credit.

Date: Oct. 2, Perinatal Association of Michigan Conference on Risk Assessment, Screening and Management. **Location:** Long's Convention Center, Lansing. **Sponsor:** Perinatal Association of Michigan. **Co-Sponsor:** E. W. Sparrow Hospital. **For:** All interested physicians. **Cost:** PAM Members: \$35, Non-PAM Members: \$50. **Contact:** Max Alderson, Michigan Dept. of Public Health, 3500 N. Logan St., P.O. Box 30035.

(continued on page 440)

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CATEGORY I/continued

Lansing, 48909. **Approved for:** 6 hours of Category I Credit.

Date: Oct. 2-5, **Michigan Chapter, American College of Physicians Regional Meeting.** **Location:** Sugar Loaf, Cedar. **Sponsor:** Michigan Chapter, American College of Physicians. **For:** Internists and family physicians. **Contact:** Boy Frame, MD, Henry Ford Hospital, 2799 W. Grand Blvd., Detroit, 48202. 313/876-2373. **Approved for:** 20 hours of Category I Credit.

Date: Oct. 3-5, **Diagnostic Ultrasound.** **Location:** Towsley Center, Ann Arbor. **Sponsor:** U-M Office of Continuing Medical Education. **For:** All interested physicians. **Cost:** \$175. **Contact:** Towsley Center for CME, 313/764-2287. **Approved for:** 16 hours of Category I Credit.

Date: Oct. 4-5, **Anesthesia, Obstetrics and the Newborn.** **Location:** Grand Traverse Hilton, Traverse City. **Sponsor:** Wayne State University School of Medicine and Michigan Society of Anesthesiologists. **For:** All interested physicians. **Cost:** \$75. **Contact:** Wayne State University School of Medicine, Division of CME, 9B-32 Health Care Institute, Detroit, 48201, (313) 577-1180. **Approved for:** 7 hours of Category I Credit.

Date: Oct. 4-5, **8th Annual Burns Clinic Medical Meeting.** **Location:** Holiday Inn, Petoskey. **Sponsor:** Burns Clinic Medical Center. **For:** All interested physicians. **Cost:** \$120. **Contact:** J. R. Postle, MD, Burns Clinic Medical Center, P.C., Petoskey, 49770, 616/347-7000, ext. 422. **Approved for:** 12 hours of Category I Credit.

Date: Oct. 6-8, **Diabetes Mellitus Symposium.** **Location:** Towsley Center, Ann Arbor. **Sponsor:** U-M Office of Continuing Medical Education.

For: All interested physicians. **Cost:** \$200. **Contact:** Towsley Center for CME, 313/764-2287. **Approved for:** 20 hours of Category I Credit.

Date: Oct. 8, **Selected Topics in Practical Cardiology.** **Location:** Education & Research Center, Henry Ford Hospital. **Sponsor:** Henry Ford Hospital. **For:** All interested physicians. **Contact:** Medical Education, Henry Ford Hospital, 2799 W. Grand Blvd., Detroit, 48202 313/876-1464. **Approved for:** 7 hours of Category I Credit.

Date: Oct. 10-11, **Michigan Fall Radiological Conference.** **Location:** William Beaumont Hospital, Royal Oak. **Sponsor:** William Beaumont Hospital. **For:** Radiologists. **Contact:** J. Farah, MD, Dept. of Radiology, William Beaumont Hospital, Royal Oak, 48072. **Approved for:** 14 hours of Category I Credit.

Date: Oct. 15, **Pediatrics Infections.** **Location:** Hurley Medical Center, Merliss Brown Auditorium. **Sponsor:** Hurley Medical Center. **For:** All interested physicians. **Contact:** Richard D. Garlick, Hurley Medical Center, Sixth Ave. and Begole, Flint, 48502 313/766-0142. **Approved for:** 6 hours Category I Credit.

Date: Oct. 16-18, **Implant Surgery for Joints and Tendons in the Hand.** **Location:** Blodgett Memorial Medical Center. **Sponsor:** American Society for Surgery of the Hand. **For:** All interested physicians. **Contact:** Alfred B. Swanson, MD, 290 Blodgett Professional Building, 1900 Wealthy Street, S.E., Grand Rapids, 49506. **Approved for:** 18½ hours of Category I Credit.

Date: Oct. 25, **Pulmonary Emergencies.** **Location:** Education and Research Center, Henry Ford Hospital. **Sponsor:** Henry Ford Hospital. **For:** All interested physicians. **Contact:** Medical Education, Henry Ford Hospital, 2799 W. Grand

Blvd., Detroit 48202 313/876-1464. **Approved for:** 7 hours of Category I Credit.

Date: Nov. 8, **Symposium on Empathy and Countertransference.** **Location:** Hyatt Regency Dearborn. **Sponsor:** Michigan Psychoanalytic Society. **For:** Psychiatrists. **Contact:** The Michigan Psychoanalytical Society, 16310 West Twelve Mile Rd., Suite 204, Southfield, 48076. **Approved for:** 6 hours of Category I Credit.

Date: Nov. 17-18, **Treatment of Injuries of the Hand: Primary and Definitive Care.** **Location:** Detroit Plaza Hotel. **Sponsor:** Wayne State University School of Medicine, Department of Surgery and American Society for Surgery of the Hand. **For:** All interested physicians. **Cost:** \$250. **Contact:** Gerald F. Prieur, Jr., MPA, Wayne State University School of Medicine, Continuing Medical Education, 9B-32 Health Care Institute, Detroit, 48202, 313/577-1180. **Approved for:** 19 hours of Category I Credit.

Date: Nov. 18-20, **MSMS Annual Scientific Meeting.** **Location:** Hyatt Regency Dearborn. **Sponsor:** Michigan State Medical Society. **For:** All interested physicians. **Contact:** Sherry Fent, MSMS, 517/337-1351. **Approved for:** 18 hours of Category I Credit.

Date: Dec. 13, **General Pathologic Problems Encountered in the Practice of Forensic Pathology.** **Location:** Towsley Center, Ann Arbor. **Sponsor:** Michigan Society of Pathologists. **For:** Pathologists. **Contact:** T. A. Reyman, MD, Department of Pathology, Mt. Carmel Mercy Hospital, Detroit, 48235. **Approved for:** 3 hours of Category I Credit.



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DEATHS

Thomas C. Arminiski, MD Bloomfield Hills

Thomas C. Arminiski, MD, Bloomfield Hills, died May 23 at the age of 65. Doctor Arminiski received his MD from Wayne State University School of Medicine, where he later was a professor of surgery. A frequent contributor to professional journals, he was a member of the American Medical Writers Guild as well as the International College of Surgeons, The American Proctological Association and the Detroit Academy of Surgery.

Alfred A. Klein, MD Sterling Heights

Alfred A. Klein, MD, Sterling Heights, died June 8. He was 62. Doctor Klein earned his MD from Wayne State University School of Medicine in 1939. He was a staff member at William Beaumont Hospital in Troy

and South Macomb General Hospital. In addition, he was an associate professor at Wayne State University School of Medicine for 10 years.

Albert W. Nickels, MD Grosse Pointe

Albert W. Nickels, MD, Grosse Pointe, died May 30 at the age of 78. Doctor Nickels earned his MD from Wayne State University School of Medicine in 1939. He was medical director of the New York Central Railroad for 16 years before joining the Ferndale Clinic and the staff of old Grace Hospital.

Donald T. Olson, MD Detroit

Donald T. Olson, MD, Detroit, died June 18. He was 47. Doctor Olson was president of the Michigan Society of Obstetricians and Gynecologists. He was on the staff of Mt. Carmel, Mercy, Beaumont, Providence and Sinai hospitals in Detroit. Doctor Olson received his MD from the University of Michigan Medical School in 1958. He was a diplomate of the American Board of Obstetricians and Gynecologists, and a fellow of the American College of Obstetricians and Gynecologists.

Robert F. Rentenbach, MD Grosse Pointe Farms

Robert F. Rentenbach, MD, Grosse Pointe Farms, died June 2 at the age of 61. Doctor Rentenbach was medical director for Detroit Edison Company and also was on the staff of Detroit Memorial and Cottage hospitals. He was a fellow of the American College of Surgeons and a member of the Detroit Society of Industrial Physicians. He earned his MD from Wayne State University School of Medicine in 1944.

Howard C. Walser, MD Birmingham

Howard C. Walser, MD, Birmingham, died May 24. He was 80. Doctor Walser was the third Michigan physician certified by the American Board of Obstetricians and Gynecologists. He was a past president of the Michigan Society of Obstetricians and Gynecologists and practiced at Henry Ford, Women's and Beaumont hospitals. He received his MD from the University of Michigan Medical School in 1923.

CLASSIFIED

The rate for each classified advertisement in *Michigan Medicine* is 15¢ per word, with a minimum charge of \$7.50. Copy for classified advertisements should be received not later than the first of the month preceding the month of publication.

Positions open

Anesthesiologist Wanted to join the Central Wisconsin Anesthesiology, S.C., which consists of three established, hospital based anesthesiologists. All specialties are served including open heart, neuro, obstetrics and gynecology. If interested, phone 715/845-5505, or write to: Central Wisconsin Anesthesiology, S.C., 425 Pine Ridge Blvd., Suite 207, Wausau, WI 54401.

The Board of Health, Marquette County, Michigan, is accepting applications for the position of Health Officer/Medical Director. Requirements for the position are certification in preventive medicine or public health; or MPH or MSPH degree and not less than 2 years of full-time public health practice; or not less than 3 years of full-time public health practice and 24 graduate credits acceptable toward public health degree; and license to practice in Michigan. Salary \$50,000 per year but negotiable according to qualifications and experience; liberal fringe benefits. The Marquette County Health Department is a single county department located in Michigan's beautiful upper peninsula which features a wide range of year-round outdoor activities; excellent living conditions. Send curriculum vitae to: Chairman, Marquette County Board of Health, 184 US 41 Highway, Negaunee, Michigan 49866 prior to September 1, 1980. An Equal Opportunity Employer.

Indiana — Fort Wayne. Emergency Physician needed. Experience and ability to meet board credential requirements desirable. Unique organization, multiple hospital group owned by all the physicians. Profits returned to physicians, not to entrepreneur. Contact American Medical Services Association, Inc., 4400 Broadway, Suite 306, Kansas City, Missouri, 64111. (816) 931-3040.

GP or Family Practice to join a 4 man group in West Central Iowa. Good community, and fairly new 100 bed hospital. Large practice opportunity here immediately, night and week end call shared equally. Guaranteed income, early partnership available. Call or write, Ed Murphy, Clinic Manager, Carroll Medical Center, 502 N. Court St., Carroll, Iowa 51401.

Locum Tenens: Needed for established pediatric practice in beautiful Marquette, Michigan on Lake Superior in the Upper Peninsula. 50% office and 50% hospital pediatric practice with Level II NICU. Needed August 1980 to June 1981. Contact: Dale C. Alverson, MD, 1414 West Fair Avenue, Marquette, MI 49855. (906) 228-6704 or 228-9440 and page.

Physician Wanted for Jackson Med Center, Inc., a non-profit clinic. Position includes directing capable medical support staff, monitoring and providing patient care and planning for future expansion of present and

PAM sponsoring Oct. 2 meet on risk

The Perinatal Association of Michigan (a cosponsor of the annual MSMS Conference of Maternal and Perinatal Health) is planning a Category I conference on risk assessment, screening and management Oct. 2 at Long's Convention Center, Lansing.

Registrations must be made by Sept. 19 for the all-day meeting, which will award up to six hours of Category I credit. The course is planned to acquaint participants with problems of clinical care which require multi-disciplinary or multi-level interactions.

Physicians' registration fees are \$35 for PAM members, \$50 for non-members.

Further information is available from Max Alderson, Michigan Department of Public Health, 3500 N. Logan St., PO Box 30035, Lansing, 48909.

future services provided. Ideal opportunity for aggressive physician interested in operating a "no risk" general practice. Internists and/or Family Practitioner preferable. Excellent salary presently up to \$50,000 and fringe benefits. No investment required. Max. 40 hour work week. Resumes to: Jackson Med Center, Inc., 312 First Street, Jackson, MI 49203. Attention: E. Willoughby, MD.

OB-GYN: Board eligible or certified to join established mixed group including 2 ob-gyn spec. Ob practice directed toward family oriented childbirth concepts. Income and responsibility of existing Ob practice divided equally from first day of employment. Professional corp. with many fringe benefits. Excellent office and hospital facilities located in beautiful vacation area. Please send resume to: Robert J. Pranger, Bus. Adm., Medical Arts Group, P.C., 20 Cobb St., Cadillac, MI, 49601 or call (616) 775-6521.

Positions With The State Of Michigan — Currently taking applications for positions expected to be available in the future. Primarily interested in board certified or board eligible internists with cardiology background. Office locations in Southfield, Lansing, and Traverse City. Also considering an office in Kalamazoo. Salary in 50's with approximately 40% fringe benefits. An equal opportunity employer. All inquiries treated confidentially. For further details please write: Disability Determination Service, P.O. Box 30011, Lansing, MI 48909, or call collect: Harry D. Nesmith, MD, Chief Medical Consultant (517) 373-7830. In Michigan, call toll free 1-800-292-2710.

Wanted: Family practitioner for Kingsley, Michigan, growing community 15 minutes south of Traverse City. Serves rural population of 12,000. Drugstore in Kingsley. Two hospitals in nearby Traverse City. Office space available. Contact James Hall, DDS, 216 W. Main St., Kingsley, Michigan, 49649, 616/263-7331.

Central Michigan University is seeking to purchase the part-time services of a physician (MD or DO) to supervise the activities of the University's Athletic Medicine Program, perform sports physicals and render medical care for inter-collegiate athletes. Approximately 20 hours per week. Experience in treating trauma. Some travel involved. Contract negotiable. Contact Ed C. Brown, Director, University Health Services, Central Michigan University, Mt. Pleasant, MI 48859, 517/774-3055. CMU is an affirmative action, equal opportunity employer.

Director of Internal Medicine. Internal medicine residency program director sought for 181-bed community hospital in Southeast Michigan, which is currently involved in a major expansion of its programs and facilities. The hospital's service area includes many affluent suburbs. In addition, it affords ample opportunity for cultural enrichment, both winter and summer recreation, and professional sporting events. St. Joseph Mercy Hospital, Pontiac, presently has 24 residents in internal medicine. Seeking board-certified academic internist whose work would emphasize resident and medical student teaching; and supervision of patient care activities. Subspecialty training preferred. Excellent fringe benefits; salary negotiable. Contact Doctor Lawrence J. Zgliniec, Director of Medical Education, 900 Woodward Ave., Pontiac, Michigan, 48053; or call (313) 858-3230.

Miscellaneous

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AAP has 10 major goals for young

The following 10 goals have been selected by the American Academy of Pediatrics as action initiatives throughout 1980 and for the future:

- All children should be wanted and born to healthy mothers.
- All children should be born well.
- All children should be immunized against the preventable infectious diseases for which there are recommended immunization procedures.
- All children should have good nutrition.
- All children should be educated about health and health care systems.
- All children should live in a safe environment.
- All children with chronic handicaps should be able to function at their optimal level.
- All children should live in a family setting with an adequate income to provide basic needs to insure physical, mental and intellectual health.
- All children should live in an environment that is as free as possible from contaminants.
- All adolescents and young people should live in a societal setting that recognizes their special health, personal and social needs.

A special June 24 celebration was held at Children's Hospital of Michigan in Detroit, which is located near Detroit's Harper Hospital, the site on which the Academy was founded. It was here that the 34 founders of the American Academy of Pediatrics drafted and signed the Academy's original constitution on June 23 and 24, 1930.



Full service benefit insurance — a time for truth, a time for change

By John R. Ylvisaker, MD, MSMS President

In previous President's Page columns, I have stressed the need for MSMS and its member physicians to be actively involved with three major issues:

- The reimbursement of health care services by full service benefit insurance.

- Regulation of the health care system.

- Health planning.

I have laid heavy emphasis on these issues because almost all of the current socio-economic problems of the health care industry can be traced to the status of these issues as root causes. I am convinced that, as major participants, physicians must understand the issues and take a leading role in change.

Fundamental relationship

It is important to be sure we all recognize the relationship of the three issues: Full insurance coverage of 90 percent of the population has fueled a remarkable increase in demand for services. Providers have responded with large increases in supply of services, facilities, and technology. Cost has risen proportionately but also has been magnified by inflation and technology.

Since neither provider nor consumer has had any financial risk or direct concern for cost because of over-insurance, those who ultimately shoulder the cost burden (government, industry, and insurers) have moved to control that cost.

The first approach to the control of cost has been to control

the supply side of the cost equation — e.g., to legislate certificate of need and health planning. The failure of this approach has led to more stringent direct control by regulation of the supply of services — e.g., bed reduction, moratorium on certificates of need, regulation of insurers and providers, legislation of cost containment measures.

It is also essential to have a full grasp of the scale and relative magnitude of costs involved. Consider the following:

Year	Total Health Care Cost	% of GNP
1960	\$ 27 billion	
1965	43 billion (Medicare enacted)	6.2%
1970	75 billion	7.6%
1975	132 billion	8.6%
1980	244 billion	9.5%
1990	723 billion	11.5%

Economists for some time have quietly been acknowledging that the reason for excessive cost has been our first-dollar coverage, cost-plus, over-insurance reimbursement system which makes people (patients, doctors and hospitals as well) act in non-economic ways, resulting in excessive investment and inappropriate use.

However, economists, together with government, health planners, and providers, have continued to ignore this basic conclusion on the premise that the financing system (the demand side of the equation) can't be changed.

Turning point

Fortunately, nationally, we are at a turning point, as we begin to realize the reimbursement system can and must be changed. People also are recognizing the solution lies in the free marketplace, where the consumer sees and counts the cost, decides whether what he is getting is worth the price. The solution includes the obvious consequence that the provider is at risk financially when the consumer must be directly "eyeballed" over the value and cost of the service.

More insidiously, the way services are paid for too frequently determines what and how many services we order. Our dependence on the luxury of ordering diagnostic and therapeutic services at no tangible cost has led to "standards" of care determined by customary usage and not by value, need, or outcome.

Let a patient come to us pleading, "Doctor, I don't have insurance," and we then get to true standards of a good history and physical and down-to-earth, practical medical care. However, we may have the misfortune of now being judged by our peers and in the courts according to custom rather than standards of good basic medical care.

However, an environment of change has been initiated which is ripe for our entry as a positive force to design new approaches, to encourage and support new initiatives, to encourage or mold new legislation, to restore and sustain the free medical market.

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Before prescribing, please consult complete product information, a summary of which follows:

Indications: Relief of anxiety and tension occurring alone or accompanying various disease states. Efficacy beyond four months not established by systematic clinical studies. Periodic reassessment of therapy recommended.

Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Warn patients that mental and/or physical abilities required for tasks such as driving or operating machinery may be impaired, as may be mental alertness in children, and that concomitant use with alcohol or CNS depressants may have an additive effect. Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported.

Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and

acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

Usual Daily Dosage: Individualize for maximum beneficial effects. Oral—Adults: Mild and moderate anxiety and tension, 5 or 10 mg t.i.d. or q.i.d.; severe states, 20 or 25 mg t.i.d. or q.i.d. Geriatric patients: 5 mg b.i.d. to q.i.d. (See Precautions.)

Supplied: Librium® (chlordiazepoxide HCl) Capsules, 5 mg, 10 mg and 25 mg—bottles of 100 and 500; Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10; Prescription Paks of 50, available singly and in trays of 10. Libritabs® (chlordiazepoxide) Tablets, 5 mg, 10 mg and 25 mg—bottles of 100 and 500. With respect to clinical activity, capsules and tablets are indistinguishable.

*synonymous
with relief of anxiety*

ROCHE

Roche Products Inc.
Manati, Puerto Rico 00701

Please see following page.

Librium®

chlordiazepoxide HCl/Roche
5 mg, 10 mg, 25 mg capsules

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Please see preceding page for a summary of product information.

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MICHIGAN MEDICINE

September 1980

JOURNAL OF THE MICHIGAN STATE MEDICAL SOCIETY

Vol 79 No 26



Who to call at MSMS headquarters

Advertising (in <i>Michigan Medicine</i>)	Bonnie Groff
AMA Delegation	Bruce Ambrose, Wayne Burmeister
Annual Scientific Meeting	
Program	Sherry Fent
Meeting Arrangements	Marce Ireland
Arbitration	Bill Madigan
Auto Lease Plan	Wayne Burmeister
Blue Cross Blue Shield	John Richards
Board of Medicine	Kevin Kelly
Continuing Medical Education	
Accreditation	Marce Ireland
Category I Calendar (for <i>Michigan Medicine</i>)	Bonnie Groff
MSMS-Sponsored Conferences	Sherry Fent
Dues Payments	Jerry Trahan
Financial Operations	Dick Campau
Foreign Medical Graduates	Mert Scholten
Governmental Agencies Liaison	Sherry Wellman
Health Career Information	Mert Scholten
HMOs (Health Maintenance Organizations)	John Richards
HSA Support Center	Dennis Paradis
Impaired Physicians	Marcelyn Ireland
Jail Health Project	David Schut
Judicial Commission	Vada Davis
Legislation	Bruce Ambrose
Maternal Health Committee and Conference	Katie Brewbaker
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Medical Assistants	Caroline Rich
Medical Auxiliary	Caroline Rich
Medical Care Costs	John Richards
Medical Ethics	Vada Davis
Medigram	Judy Marr
Meeting Information (National, State)	Bonnie Groff
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Michigan Society of Respiratory Therapists	Caroline Rich
MSMS Committee Meeting Schedule	Katie Brewbaker
MSMS House of Delegates	
Agenda and Schedule	Dick Campau
Meeting Arrangements	Marce Ireland
MSMS News Relations	Mert Scholten
MSMS-Sponsored Insurance Programs (Life, Health, etc.)	Wayne Burmeister
MSMS Travel Programs	Marce Ireland
Physician Hospital Relations	Dick Campau
Physician Legislative Network	Kevin Kelly
Physician Service Group	John Anthony
Practice Management Seminars	John Anthony
Professional Liability Insurance	Bill Madigan
PSRO	Sherry Wellman
Socio-Economic Surveys	John Richards
Specialty Societies	
Information	Katie Brewbaker
Council of Specialty Societies	Bill Madigan
Third Party Payors	John Richards

MSMS ADDRESS: Michigan State Medical Society MSMS PHONE: 517/337-1351
120 West Saginaw (Box 950)
East Lansing, MI 48823

The impressive Hyatt Regency Dearborn, with its smooth "people mover" shuttle to Fairlane Center shops, restaurants and entertainment, is the site again of the 1980 MSMS Annual Scientific Meeting. Michigan physicians may register now with the form on page 459 of this issue. (Photo by Mert Scholten, MSMS staff.)

MICHIGAN MEDICINE

September 1980, Vol. 79, No. 26

Special report

- 452** The biggest annual MSMS event — the 1980 MSMS Annual Scientific Session — is the subject of this month's special report. *Michigan Medicine* contributors have compiled eight pages of articles and photos on the courses, speakers, the hotel and its accommodations, Detroit metropolitan area attractions, exhibitors, and specialty society meetings planned concurrently with the Annual Scientific Meeting. The registration form completes the package on page 459.

Features

- 460** Michigan physicians were part of the Republicans' big July show in Detroit; Willah Weddon
- 465** How Michigan hospitals are coping — or not bothering — with the recession; Dwight Angell
- 470** This Michigan physician found the Chinese hospitable; Sander J. Breiner, MD
- 474** Third in a series: The Indochinese refugees, with looks at Vietnamese culture, malnutrition's effects, and hepatitis B; Sugnichand Sukhani, MD
- 483** Medical students have increasing debts, and the situation will bring profound changes to medical education; John Richards
- 506** In memoriam: Robert E. Rice, MD; Herbert A. Auer

Departments

- 448** Editorial; Samuel M. McMahon, MD
- 449** Letters
- 451** Health Planning Update
- 488** Meetings
- 495** Category I courses
- 498** News
- 500** New members
- 508** Deaths
- 508** Ad index
- 509** Classified ads
- 510** President's page; John R. Ylvisaker, MD

EDITORIAL

MSMS Annual Scientific Meeting is practical, diverse, inexpensive



By Samuel M. McMahon, MD, Lansing

It is time again to plan to attend the Annual Scientific Meeting of the Michigan State Medical Society. It will be held again this year at the Hyatt Regency Dearborn, on Tuesday, Nov. 18, Wednesday, Nov. 19, and Thursday, Nov. 20. The catalogue of courses offered and a preregistration form are going out to the membership this month. There are several reasons why it is important for you to attend the annual meeting of your state medical society:

1) *The program is excellent.* We bring together the finest CME talent available in Michigan. Although some of the speakers are from out-of-state, we find consistently that our faculty from Michigan perform as well or better than any other talent available in CME. All of the people presenting and the program directors are experienced teachers who know something about the best way to present an educational program. We also have access to the specialty societies in Michigan as well as the universities and we have drawn heavily from this pool of talent for the annual meeting.

2) *The program is inexpensive.* It only costs about \$5 per category I credit hour for the courses offered. Unlike some other organizations, our aim is to break even. MSMS does not make a profit from the annual meeting.

3) *The program is diversified.* It is difficult to find another meeting where there are so many different topics which may interest a generalist or a specialist. Most CME programs deal extensively with one topic or several topics only. In this meeting you can learn anything from practical topics in pediatrics to clinical toxicology in adult patients.

4) *The program is practical.* Our emphasis this year, as in years past, will be upon a hands-on, participative approach to clinical problem solving. In most of our courses, provision will be made to see and hear about real cases and to participate, in a vicarious way, in solving the problems.

Several new areas this year which were not covered in previous years include the physician's role as an expert witness and advocate for the patient, the physician's role in educating colleagues in the community hospital, the role of physicians in health planning, and two sessions specifically designed for the use of anti-depressant and anti-anxiety drugs.

Some of our courses will encourage participants to bring cases from their own practices for discussion by the panel of experts on the faculty. These courses will include Robert McKnight, MD's, course on "Diagnosis and Treatment of Colon and Rectal Disease," James Ausman, MD's, course on "Multidisciplinary Approach to Back Pain," Erwin Haas, MD's, course on "Office Management of Common Infectious Problems," and David S. Greenbaum, MD's course on "Chronic Abdominal Pain." Physicians wishing to bring a case must contact the program director prior to the annual meeting and must limit their presentation to less than five minutes.

I hope you will sign up well in advance of the annual meeting for the many fine courses offered and help support your Michigan State Medical Society's efforts in making the best in CME available to you.

Doctor McMahon is chairman, 1980 MSMS Annual Scientific Meeting.

Michigan State Medical Society
Warren F. Tryloff, director

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Judith Marr

Michigan Medicine, the official journal of the Michigan State Society, is dedicated to provide useful information for Michigan physicians about actions of the Michigan State Medical Society and contemporary issues, with special emphasis on socio-economics, legislation and new about medicine in Michigan. Major medical developments will be reported and interpreted as has been the custom.

The Michigan State Medical Society Committee on Publications is the editorial board of *Michigan Medicine* and advise the editors in the conduct and policy of the magazine, subject to the policies of the MSMS Council.

Neither the editors nor the state medical society will accept responsibility for statements made or opinions expressed by any contributor in any article or feature published in the pages of the journal. The views expressed are those of the writer and not necessarily official positions of the society. Products and services advertised in *Michigan Medicine* are neither endorsed nor warranted by MSMS.

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Metropolitan Life asks MDs' help in new claims processing system

This is a request for physicians' assistance in helping General Motors retirees and surviving spouses submit their health care claims and to help us pay claims promptly.

Metropolitan Life Insurance Company is the health care insurance carrier for a large number of General Motors retirees, surviving spouses and their dependents. Through an arrangement with the government and the carriers handling Medicare Part B, Metropolitan has developed a special claims processing system for General Motors retirees and surviving spouses. Retirees and surviving spouses enrolled in the "General Motors Retiree Health Care Servicing Program" have been issued an identification card.

Under this servicing program, the physician files all claims directly with Metropolitan. This filing is done using Metropolitan and/or standard billing forms. Metropolitan will promptly pay the provider the reasonable and customary fee for covered services rendered. There are no deductibles and no copayments involved (with the exception of outpatient psychiatric services). Following payment, Metropolitan, through the

arrangement mentioned above, will seek reimbursement from the Medicare carrier. Any services not covered by Metropolitan will be forwarded to the Medicare carrier for processing.

The advantage of this system to the physician is the prompt payment of claims by Metropolitan without the need to submit claims to Medicare. The advantage to the patient is the payment of the full scope and level of General Motors Health Care Coverage without the need to suffer out-of-pocket expenses while waiting for reimbursement from Medicare. We urge physicians not to file with both Medicare and Metropolitan since this could result in delay and possible duplicate payment which would have to be repaid. We would appreciate your cooperation in the direct filing of claims with Metropolitan for your patients who are General Motors retirees or surviving spouses and who present the distinctive identification cards.

Paul S. Entmacher, MD
Vice-President and
Chief Medical Director
Metropolitan Life Insurance
Company
New York

MPMLC ad ok; Medical Protective ad shouldn't appear

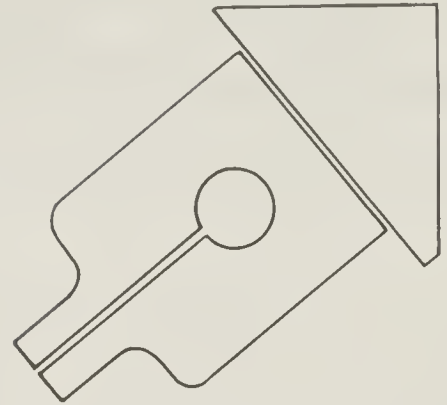
I was impressed with the advertisement on page 391 of the July 1980 issue of the State Medical Society (for the Michigan Physicians Mutual Liability Company). With greater participation the cost can be reduced for insurance coverage.

By the same token, I object to the advertisement on page 395 placed by the "Cherry Picker" known as the "Medical Protective Company" of Fort Wayne, Indiana. I think we should do all we can to avoid use of

such a stock company whose avowed purpose is good returns (35-42 percent) to its stock-holders; not good insurance coverage to physicians who carry a greater risk indigenous to their type of practice.

I do not think they should be allowed to advertise in our State journal; no more so than Volkswagen can advertise in the General Motors News.

John W. Vincent, MD
Dearborn Heights



Corrections

Michigan Medicine regrets errors appearing in the article, "New day dawns for the patient at Department of Mental Health," pg. 416, August, 1980, Michigan Medicine.

There were 150,000 persons, rather than 15,000, treated last year by community mental health agencies. 34,000 persons, rather than 134,000, received care in licensed psychiatric units of general and private hospitals.

V.A. Stehman, MD, is chief deputy director, and Wesley Pomeroy is chief of staff with the MDMH. Their positions were incorrectly stated in the article.

half-life

Just one built-in advantage

Ensures smooth therapeutic effect even if a dose is missed The relatively longer half-life of Valium® (diazepam/Roche) has important clinical and pharmacological implications. Steady-state levels generally are reached within 5-7 days with no further accumulation. At this plateau, the patient benefits from the consistent, steady response you expect. Sharp blood level variations, frequently attributed to agents with a short half-life, do not appear with Valium.

Avoids sudden symptom breakthrough

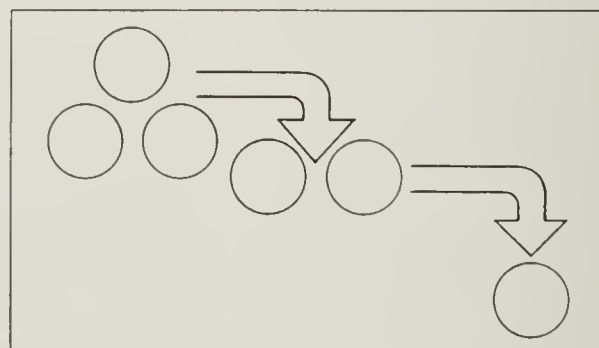
Once steady-state levels are achieved, sudden reemergence of symptoms is unlikely. Diazepam and its active metabolites exhibit overlapping half-lives that are advantageous not only during therapy but especially when pharmacologic support is discontinued. Elimination rates are gradual with Valium and thus provide a compatible adjustment interval for

the patient. In comparison, blood levels of short-acting agents with inactive metabolites decrease more rapidly and are more likely to be associated with withdrawal symptoms if medication is stopped abruptly.* With Valium unwanted effects other than drowsiness or ataxia are rare. Patients should be cautioned about driving and advised to avoid alcohol.

Tapers naturally; complements gradual dosage reduction at discontinuation

When any psychoactive medication is discontinued, it is good medical practice to gradually reduce the dosage. From your own experience you know this is rarely necessary after a short course of Valium therapy, but for patients on extended therapy, gradual reduction of dosage is advisable. This regimen, along with the self-tapering feature of Valium, provides a smooth transition to independent coping.

*Sellers EM: *Drug Metab Rev* 8(1):5-11, 1978



*in the management of
symptoms of anxiety*

Valium®
diazepam/Roche
2-mg, 5-mg, 10-mg scored tablets

*effective therapy through
efficient pharmacodynamics*

Valium[®] diazepam/Roche

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Management of anxiety disorders, or short-term relief of symptoms of anxiety, symptomatic relief of acute agitation, tremor, delirium, tremors and hallucinosis due to acute alcohol withdrawal, adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, ataxic gait, stiff-man syndrome, convulsive disorders (not for sole therapy).

The effectiveness of Valium (diazepam/Roche) in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma. May be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication. Abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms similar to those with barbiturates and alcohol have been observed with abrupt discontinuation, usually limited to extended use and excessive doses. Infrequently, childer withdrawal symptoms have been reported following abrupt discontinuation of benzodiazepines after continuous use, generally at higher therapeutic levels, for at least several months after extended therapy gradually taper dosage. Deep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed, drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances. Stimulation have been reported, should these occur, discontinue drug. Isolated reports of neutropenia, jaundice, periodic blood counts and liver function tests advisable during long-term therapy.

Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

HEALTH PLANNING UPDATE

By Dennis Paradis, Director
MSMS Physician/HSA Support Center



AMA views bed reduction

In the belief that some type of bed reduction program will be implemented in other states, the AMA is reviewing the Michigan hospital bed reduction program. Ron Bryant of the AMA staff visited Michigan in July to interview several people and prepare a report for the AMA Ad Hoc Committee on Health Planning.

As a result, Robert Toteff, MD and Dennis Paradis of the MSMS staff were invited to make a presentation before this Committee at their Sept. 6 meeting in Lincolnshire, Ill.

Doctor Toteff is well-acquainted with the bed reduction program through his role as an MSMS Councilor, member of the MSMS Steering Committee on Health Planning, vice-chairman of the Statewide Health Coordinating Council (SHCC) and vice-chairman of the SHCC Ad Hoc Committee on Bed Reduction. Mr. Paradis is Coordinator for Health Planning for MSMS.

State medical facilities plan aired

The proposed State Medical Facilities Plan (SMFP) for 1979-80 was released for public hearings in early September. This plan will be used as the guideline for certificate of need applications by the state.

The plan is not part of the hospital bed reduction effort, although it identifies 5,100 excess hospital beds in the state through application of the Acute Care Bed Need Methodology. This is the same formula used in the hospital bed reduction program, although the number of excess beds was scaled down to 3,800.

The use of the Acute Care Bed Need Methodology, which assumes appropriate medical/surgical utilization should not exceed a norm of 1,000 days per 1,000 population, is expected to be challenged.

The response to the formula used to determine nursing home bed need is less certain. This formula has been challenged by physicians in some rural areas for not permitting an adequate number of nursing home beds to meet patient needs.

The MSMS Steering Committee on Health Planning is currently evaluating the nursing home formula and will make recommendations to the MSMS Council if necessary.

Physicians wishing to submit comments regarding the adequacy of the number of nursing home beds in their areas should contact Mr. Dennis Paradis at MSMS.

Bring yourself up-to-date painlessly, Doctor: attend the 1980 MSMS Annual Scientific Meeting

What's the best reason for an MSMS member to attend the 1980 MSMS Annual Scientific Meeting Nov. 18-19-20 at the Hyatt Regency Dearborn?

Here's what some of the directors of the 54 Category I courses planned for the three-day session suggest:

"Our course is given by private, practicing physicians." —Agustin Arbulu, MD, Detroit, "Current Concepts in Medical and Surgical Management of Ischemic Heart Disease."

"Because of important medical, legal and economic issues regarding this common procedure, the practicing physician who performs or refers patients for this procedure should be aware of the most current and informed opinions regarding adenotonsillectomy." —Ronald S. Bogdasarian, MD, Westland, "Tonsillectomy and Adenoidectomy 1980: Recent Advances in Otitis Media."

"The fact that we plan to handle a relatively 'hot' subject without scorching anybody; that we hope to weave together out of myth, mystery, prescriptions, proscriptions and prognostications a lumpy fabric which may serve as a tapestry of the present state of the art." —Ruth S. Day, MD, St. Clair Shores, "Abortion: Some Aspects."

"The areas covered are discussed frequently by patients, but are not commonly covered in a fashion which permits the physician to take something back to the office." —Bruce H. Drukker, MD, Detroit, "Management of Problems in Office Gynecology."

"Psychiatric emergencies occur in every area of medicine. Medical school and residency training generally ignore the practical aspects of emergency psychiatric issues, leaving the physician to devise his own

methods of handling these problems." —Bonnie J. Fauman, MD, Detroit, "Emergency Psychiatry."

"Nuclear medicine offers a different type of 'window' to the patient. Whereas most other imaging studies evaluate anatomy, nuclear is more reflective of physiology. Thus, they can detect early pathologic changes and provide another perspective to patient care." —Daniel S. Marks, MD, Detroit, "Nuclear Medicine: Better Use of Available Tests."

Each course director has important reasons why his or her course will be worth attending — all of the courses are designed to help Michigan physicians in day-to-day practice.

"The main advantages are that one can learn from recognized experts in a stimulating environment, and can be brought up to date painlessly," says Samuel M. McMahon, MD, Lansing, Annual Scientific Meeting chairman.

Doctor McMahon and his task force are introducing some courses this year in which the participants will be invited to present actual cases for discussion by the experts. Another special program, designed to help physicians become better expert witnesses in legal situations, will include simulated courtroom situations and testimony.

Several courses will be devoted to new developments in management of chronic pain. Emergency and

trauma situations also will be the topic of a large group of courses.

The three-day format includes a two-day advanced cardiac life support course awarding certification and 16 hours of Category I credit, which is preceded by a one-day course in basic life support.

In many cases, specialties will have a full day of courses. At the same time, the courses are being planned with the family physician in mind, and the American Academy of Family Physicians approval for prescribed credit is pending for most courses.

Most of the MSMS staff, led by Coordinator of CME Programs Sherry L. Fent, will be at the Hyatt Regency Dearborn to register physicians, sell course tickets, handle arrangements and serve as course assistants.

Physicians are urged to register early, particularly for the Advanced Cardiac Life Support course, which has a limited enrollment.

Registration forms for all courses are printed in the first September Medigram and on page 459 of this issue. Those needing room reservations are urged to contact the Hyatt Regency soon and let the reservation clerk know they are part of the MSMS conference, to take advantage of the special room rate. Physicians may make room reservations directly before Nov. 1, by calling the Hyatt at 313/593-1234.

This special eight-page section has all the details on the 1980 MSMS Annual Scientific Meeting. Please be sure to check the photo gallery of course directors, the course reservation form on page 459, and feature stories on the speakers, hotel, local attractions, and exhibitors.



Hyatt Regency glows with light.

In Mid-November, Metro area is full of attractions

By Shelton Reece, special to Michigan Medicine

The pre-holiday season, November 18, 19, and 20, is an excellent time to become acquainted — or reacquainted — with the attractions in Dearborn and the Greater Detroit Area.

When you are not attending courses during the MSMS Annual Scientific Meeting, you may want to do some early holiday shopping at Fairlane Town Center just a minute-and-a-half's automatic vehicle ride from your hotel.

This impressive complex of 186 shops and 17 restaurants now boasts the newest and most elegant Saks Fifth Avenue store in the region.

Holiday Hyatt

Staying at the Hyatt Regency Dearborn is like a holiday in itself. The spectacular crescent-shaped, 800-room hotel offers just about every amenity.

Rooms and suites are luxurious, with tasteful decorations and unobstructed views of the surrounding area.

Recreational facilities include an indoor, heated 32-foot-in-diameter circular swimming pool, a whirlpool for complete relaxation, and an Arizona dry-heat sauna. Regency guests also can enjoy nearby Fairlane Manor which offers indoor and outdoor swimming, tennis, racquetball and handball courts, bowling, bil-

liards, as well as men's and women's exercise rooms.

Opportunities for relaxation and dining at the Hyatt are delightfully extensive.

The Lobbi Bar on the first level serves cocktails from morning until midnight, with a pianist on hand Tuesday through Saturday nights. Kafay's Place serves contemporary cuisine for breakfast, lunch and dinner. The Rotunda, located on the 16th floor, is a revolving rooftop restaurant; and La Rotisserie, the hotel's gourmet restaurant serves dinner Monday through Saturday. La Prelude is an intimate lounge adjacent to La Rotisserie. Giulio & Sons serves lunch Monday through Saturday and dinner daily from 6 until 10:45 PM, and db's Club is a showcase for well-known entertainers. Room service is available at the hotel from 6:30 AM until 1:30 AM daily.

Detroit attractions

You also will want to allow time for the nearby Greenfield Village and the Henry Ford Museum which are open every day. The 260-acre complex was created more than half a century ago by Henry Ford to preserve for future generations the interesting and important objects that were part of early America.

Of course, the entire Greater Detroit area offers events that will help

make your short stay there memorable.

Among those you may wish to investigate are: Detroit Institute of Arts' major sculpture exhibits, "The Romantics to Rodin," which is composed of 400 pieces of the finest 19th Century French sculpture owned by museums and private collectors throughout the United States (call 833-7900 for hours). At the Music Hall Theatre, Detroit, the Laura Dean Dancers, a highly acclaimed modern ballet group, open an engagement November 19th (963-7680); Fisher Theatre (872-1000) also is booked during your stay, however, the attraction was unannounced at press time; a Detroit Pistons game is scheduled to be played at the Pontiac Silverdome (857-7700) on the 19th; and, if you can stay over an extra day, the Detroit Symphony Orchestra plays the evening of November 21st at Ford Auditorium, Detroit, (962-5524) with Lynn Harrell, cellist, and three choral groups performing. Other outstanding possibilities are a Detroit Red Wing game at the new Joe Louis Arena (call 962-2000 for information); "Our Town" presented at Meadow Brook Theatre, Rochester (377-3300); a play (schedule to be announced) at Wayne State University's Hillberry Theatre (577-2972), or a presentation at the Masonic Temple (832-6648).

Meet the directors for half-day courses at Scientific Meeting

Please fill out registration form on page 459



Alexander



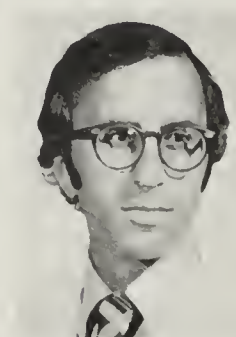
Arbulu



Ausman



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Bogdasarian



Bryant



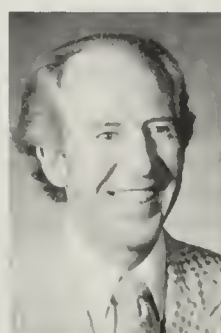
Clark



Cohn



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Danek



Day



Downs



Drukker



Elliott



Fauman



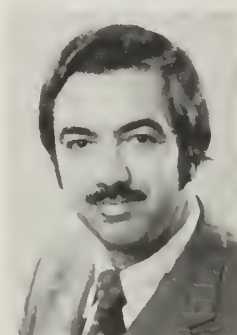
Gerard



Greenbaum



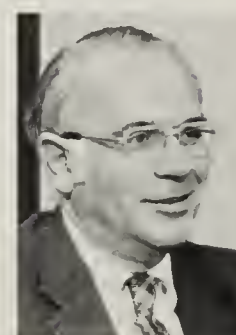
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Harness



Horan



Hunt



Kambouris

Samuel M. McMahon, MD
Scientific Meeting
Chairman



Kapur



Killip



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Lucas



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Tourkow



Tripp



Weiss



Youel

Specialties planning lunches, dinners during Annual Scientific Meeting

Specialty events and meetings go hand in hand with the MSMS Annual Scientific Meeting as many specialty organizations piggyback dinner meetings, elections and social events onto the scientific courses.

And the 1980 meeting is no exception.

Nine different specialties as well as three other groups or committees are planning events as adjuncts to the MSMS Annual Scientific Meeting.

Tuesday

On Tuesday, Nov. 18, the Michigan Otolaryngological Society is hosting a reception and dinner honoring course speakers Charles D. Bluestone, MD, professor of otolaryngology, University of Pittsburgh School of Medicine, and James A. McNamara, DDS, assistant professor, Department of Anatomy, University of Michigan Medical School.

The Council of the Michigan Society of Obstetricians and Gynecologists will hold a luncheon/business meeting while the Michigan Chapter of the American Medical Writers Association plans an evening reception and dinner.

The other Tuesday event is being sponsored by the MSMS Committee to Assist Impaired Physicians. A reception/dinner followed by a special evening meeting to introduce the new MSMS Program to Assist Impaired Physicians will be held for all interested physicians, spouses and others with particular concerns for this program.

The program would be an ideal opportunity for component officers and leaders to learn about the program with an aim toward forming or expanding their own local committee to assist their impaired colleagues.

Wednesday

Six special events are on the

agenda for Wednesday, Nov. 19.

The Michigan Society of General Surgeons is holding a general membership meeting in the early evening to be followed by a meeting of the executive committee.

The Michigan Orthopaedic Society is hosting an evening reception/dinner/scientific meeting in addition to its regular half-day course earlier in the day.

Both the Michigan Society of Colon and Rectal Surgeons and the American Urological Association, Michigan Branch are hosting dinner/scientific meetings on Wednesday evening as adjuncts to their course offerings earlier in the day.

The Michigan Allergy Society will hold a morning business meeting on Wednesday prior to the regular scientific course being offered in the afternoon.

Regardless of specialty, graduates of the Wayne State University Medical

School will want to make plans to attend the WSU Alumni reception planned for Wednesday following the afternoon programs.

Thursday

The Michigan Psychiatric Society is using Thursday, Nov. 20 for several events including a MPS Council luncheon and a tentative general reception/dinner/scientific meeting in the evening. Likewise, the Michigan Ophthalmological Society is planning a Thursday reception/dinner meeting that evening.

Physicians from any of these specialty or interest areas as well as others should check the calendar of events for the day while attending the scientific courses for locations of these events and others which may materialize between now and the meeting itself.

Details are available now from the specialty societies and Marce Ireland at MSMS headquarters.

At-a-glance specialty schedule:

Tuesday noon, Nov. 18 — Michigan Society of Obstetricians and Gynecologists

**Tuesday evening, Nov. 18 — Michigan Otolaryngological Society
MSMS Committee to Assist Impaired Physicians
Michigan Chapter, American Medical Writers Association**

Wednesday morning, Nov. 19 — Michigan Allergy Society

**Wednesday evening, Nov. 19 — Michigan Orthopaedic Society
Michigan Society of Colon and Rectal Surgeons
Michigan Society of General Surgeons
American Urological Association,
Michigan Branch
Wayne State University
Medical School Alumni**

Thursday noon, Nov. 20 — Michigan Psychiatric Society

**Thursday evening, Nov. 20 — Michigan Ophthalmological Society
Michigan Psychiatric Society**

75 scientific, educational exhibits planned

Your attendance at the 1980 MSMS Annual Scientific Meeting won't be completed, Doctor, without a visit to the exhibit hall.

Particularly at the end of the day's CME courses, your visit to the 75 scientific and educational exhibits scheduled will provide a relaxing and informative wrap-up of activities.

It is then that the exhibitors have time to discuss products and services in more detail, after the rush of physician visits during the day.

A wide range of products and services will be available for discussion and demonstration in the MSMS exhibit hall. They include

- computer billing systems
- computerized lab services
- computerized medical records
- filing systems
- X-ray, lab systems and services
- Auto leasing
- Medical reference books
- Insurance
- Investment counselors

More than 20 drug houses will display new and trusted products. Four exhibitors have been part of the MSMS annual meeting for at least 45 years. They are Gerber Products Company, Lederle Laboratories, Medical Protective Company and W.B. Saunders Company.

Physicians seeking to relocate practices talk with representatives of the official physician placement organization for the state, the Michigan Health Council. Three branches of the armed forces — Navy, Air Force and Army — also will be recruiting.

MSMS is pleased to have the following exhibitors with them for this Annual Scientific Meeting:

Adria/Warren-Teed Laboratories
Advance Medical & Research Center, Inc.
Advance Nuclear Supply
American Timber
Ames Division, Miles Laboratories, Inc.
Binson's Hospital Supply, Inc.
Blue Cross Blue Shield of Michigan
Boehringer Ingelheim Ltd.
Burroughs Corporation
C.B.C. Laboratory Service, Inc.
Cardio Tronics



1979 MSMS Annual Scientific Meeting exhibit hall.

City Microfilm Company
City X-Ray Company
COMEDCO
Data-Med Corporation
Dearborn Clinical Laboratory
Dental Office Computer Systems, Inc.
Dista Products Company
Dow Chemical, U.S.A.
Dynamic Data Systems
E & M Medical Systems, Inc.
Encyclopaedia Britannica
Ferndale Labs, Inc.
Firestone X-Ray Corp.
First Heritage Corporation
Gerber Products Company
Girard & Associates, Inc.
Healthways, Inc.
International Medical Electronics, Ltd.
Ives Laboratories, Inc.
Laboratory Procedures, Inc, Upjohn
Lake Erie Medical
Eli Lilly and Company
Market Concepts
Master Medical Laboratory
CC/McCullagh Leasing, Inc.
McNeil Pharmaceutical
Mead Johnson Nutritional Division
Mead Johnson Pharmaceutical Division
Medical Plastics Laboratory, Inc.
The Medical Protective Company
MEDS Marketing

Merck Sharp & Dohme
MESSA
Metpath
Michigan Bell
Michigan Health Council
Michigan Nat'l Guard
Michigan Physicians Mutual Liability Company
Milex of Michigan
Michigan Nat'l Guard
National Health Laboratories
Navy Medical Programs
N.B.A. Clinical Labs
Parke-Davis
Profesco of Southfield
Quality Care Nursing Service
Reed & Carnrick Pharmaceuticals
Rollins Medical/Dental Systems
Rourk Medical Services
Sandoz Pharmaceuticals
W. B. Saunders Company
Schering Corporation
Smith Kline & French
Stratton-Cheeseman & Associates, Inc.
Surgi-Med, Inc.
Systemedics Associates, Inc.
Tab Products
Tele-Com Office Products, Inc.
United Medical Services, PC
U.S. Air Force
U.S. Army Medical Department
The Upjohn Company
Welcor Incorporated

Speakers for Annual Scientific Meeting coming from many states, specialties

Guest speakers from a score of states will be on hand to enliven the presentations scheduled for the MSMS Annual Scientific Meeting, Nov. 18-19-20.

Their subjects will range from infections to pediatric injuries.

Philip Bernatz, MD, a consultant to the Mayo Clinic Department of Surgery, Rochester, MN, will speak on "Thoracic Lymphomas" on Thursday afternoon as part of the course on common thoracic problems. On the same program will be William Lees, MD, clinical professor of surgery, Loyola University of Chicago, Stritch School of Medicine, who will cover "The Role of Surgery in the Treatment of Emphysema."

Charles D. Bluestone, MD, University of Pittsburgh School of Medicine, noted authority on the controversy surrounding tonsillectomy and adenoidectomy, will highlight a Tuesday afternoon session on that topic presented by the Michigan Otolaryngological Society. He will also speak on "Recent Advances in Otitis Media."

A thoracic trauma surgeon, David C. Green, MD, Division of Thoracic and Cardiovascular Surgery at the University of Maryland Hospital, Baltimore, is speaking on "Deceleration Injuries to the Great Vessels" on Wednesday morning.

Stuart Levin, MD, chief of Infectious Diseases, Presbyterian-St. Lukes Hospital, Rush Medical College, Chicago, offers "Office Management of ENT and of Pulmonary Infections" as part of a course on office management of common infectious problems on Thursday afternoon.

"Risk Factors and Surgical Management of Breast Lesions" is the

topic selected by John P. Minton, MD, professor of surgery and American Cancer Society professor of clinical oncology at Ohio State University School of Medicine, Columbus, during a Wednesday afternoon course on breast cancer.

Lawrence Muroff, MD, clinical associate professor of radiology, South Florida Medical College and director, Department of Nuclear Medicine at University Community Hospital in Tampa, FL, will present "A Sensible Approach to Diagnostic Imaging for the Referring Physician" during a Thursday afternoon course on nuclear medicine.

"Managing the Burn Wound" and "Treatment of Malignant Melanomas" are two topics being presented by Martin C. Robson, MD, professor of surgery and chief, section of plastic surgery, at the University of Chicago Medical School. Both topics will be given on Wednesday during courses being presented by the Michigan Academy of Plastic Surgeons.

The Michigan Psychiatric Society, responsible for several course offerings this year, has secured Richard Shader, MD, professor and chairman, Tufts University School of Medicine's Department of Psychiatry, Boston, to participate in a course on psycho-pharmacology with the topic, "The Diagnosis and Treatment of Anxiety." The course is offered on Wednesday afternoon.

"Complications and Diabetic Coma" will be offered by Charles Shuman, MD, professor of medicine at Temple University School of Medicine, Philadelphia, as part of the Tuesday afternoon course on diabetes.

Robert J. Touloukian, MD, chief,

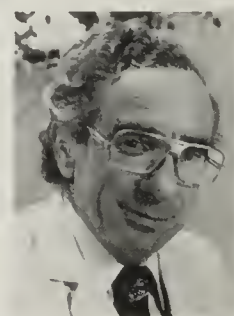
pediatric surgery, Yale University School of Medicine in New Haven, CT, will be a key speaker at a Thursday afternoon offering "Care of the Injured Child," presented by the division of pediatric surgery at Henry Ford Hospital. Doctor Touloukian's topic will be, "Management of Splenic and Hepatic Injuries."

Thomas Van Metre, Jr., MD, associate professor and physician in charge of the allergy clinic at Johns Hopkins Hospital, Baltimore, is presenting "Therapy of Asthma" on Wednesday afternoon as part of a course offered by the Michigan Allergy Society.

These guest speakers are only a sampling of the kind of variety and excellence available at this year's meeting.



Bernatz



Bluestone



Minton



Muroff

PLEASE SEND ENTIRE
PAGE WITH CHECK

1980 MSMS Annual Scientific Meeting, Hyatt Regency Dearborn
Registration Form for Category I CME Courses

* Approval for Prescribed Credit by American Academy of Family Physicians is pending for all courses except those marked with asterisk.

TUESDAY MORNING, NOV. 18
(8:30 to Noon, including break)

- (Write 1 in blank for first choice,
and 2 for second choice)
- ___ Care of the Elderly
 - ___ CME Implementation in Community Hospitals
 - ___ Current Concepts and Practical Therapeutic Approach to Non-Hodgkins Lymphoma
 - ___ Denial in Alcoholism, Substance Abuse and Mental Health
 - ___ Management of Problems in Office Gynecology
 - ___ Multi-Disciplinary Approach to Back Pain
 - ___ Occupational Medicine
 - ___ Office Management of Common Pediatric Problems
 - ___ The Wet Ear — Diagnosis and Treatment for Primary Care Physicians

TUESDAY AFTERNOON, NOV. 18
(1:30 to 5:00, including break)

- (Write 1 in blank for first choice,
and 2 for second choice)
- ___ Basic Life Support
 - ___ Brief Psychotherapy by the Primary Physician-Psychoanalyst Team
 - ___ Chronic Abdominal Pain
 - ___ Current Management of Renal Failure
 - ___ Diabetes — Current Management and New Horizons
 - ___ Emergency Psychiatry: Theory and Practice
 - ___ Physicians as Expert Witnesses: Continuing Medical Care
 - ___ Tonsillectomy and Adenoidectomy — Current Status

WEDNESDAY MORNING, NOV. 19
(8:30 to Noon, including break)

- (Write 1 in blank for first choice,
and 2 for second choice)
- ___ Advanced Cardiac Life Support (A 16-hour course to run all-day Nov. 19 and 20. See tuition below.)
 - ___ Clinical Toxicology in the Emergency Department
 - ___ Colon Polyp — Cancer Sequence: A Rational Approach
 - ___ Common Orthopaedic Problems
 - ___ Dermatology for the Non-Dermatologist
 - ___ Effectiveness of Treating Hypertensive Patients: Newer Data
 - ___ Genetic Issues in General Practice
 - ___ Health Planning: Impact on the Physician and Patient Care
 - ___ Psycho-Pharmacology: Anti-Depressants
 - ___ Skin Cancer — Including Malignant Melanoma
 - ___ Thoracic Trauma: Problems in Diagnosis, Early Management and Disposition

WEDNESDAY AFTERNOON, NOV. 19
(1:30 to 5:00, including break)

- (Write 1 in blank for first choice,
and 2 for second choice)
- ___ Bronchial Asthma in Children and Adults
 - ___ Current Approaches in Diagnosis and Management of Cancer of the Lung
 - ___ Current Concepts in the Management of Electrolyte Disorders
 - ___ Diagnosis and Curative Management of Breast Cancer
 - ___ Diagnosis and Treatment of Colon and Rectal Disease
 - ___ Everything You Always Wanted to Know About Local Anesthetics
 - ___ Injuries to the Genito-Urinary Tract
 - ___ Management of Difficult Soft Tissue Wounds
 - ___ Psycho-Pharmacology: Anti-Anxiety Agents
 - ___ Update on Cutaneous Mycology and Bacteriology — 1980

THURSDAY MORNING, NOV. 20
(8:30 to Noon, including break)

- (Write 1 in blank for first choice,
and 2 for second choice)
- ___ Chronic Head Pain
 - ___ Common Ophthalmic Problems
 - ___ Elective Surgical Procedures in the Elderly
 - ___ Management of Abortion — Current Aspects
 - ___ Non-Invasive Diagnosis of Peripheral Vascular Disease
 - ___ Pre-Paid Health Plans: Alternate Medical Care?
 - ___ Workshop on Medical Ethics

THURSDAY AFTERNOON, NOV. 20
(1:30 to 5:00, including break)

- (Write 1 in blank for first choice,
and 2 for second choice)
- ___ Arthrographic, Arthroscopic and Clinical Findings in Knee Injuries
 - ___ Cardiac Arrhythmias — Rational Use of Drugs
 - ___ Care of the Injured Child
 - ___ Common Thoracic Problems
 - ___ Current Concepts in Medical and Surgical Management of Ischemic Heart Disease
 - * ___ Muscle Contractions, Fiber Types and the Effect of Exercise Training.
 - ___ Nuclear Medicine: Better Use of Available Tests
 - ___ Office Management of Common Infectious Problems
 - * ___ Ophthalmology Symposium



The half-day courses will provide 3 hours of Category I credit toward the state relicensure requirements and the AMA Physician's Recognition Award.

Please check the courses you wish to attend. In each case, please indicate a second choice should the first choice already be filled. Maximum attendance figures have been set for each course because rooms vary in size.

Send this entire page with your check. Confirmation of your reservation will be sent to you. Your course credentials, badge, and luncheon tickets, must be picked up at the MSMS Registration Desk upon arrival at the Hyatt Regency.

Physicians must make their own hotel reservations prior to 11/1/80 direct with the Hyatt Regency Dearborn, Fairlane Town Center, Dearborn, MI 48126. In order to take advantage of the special conference rates, please mention that you will be attending the MSMS Annual Scientific Meeting.

Name _____
(please print) (first) (initial) (last)

Street _____

City, State _____ Zip _____

MSMS Member: Yes _____ No _____ Resident _____ Other _____ Specialty _____

Tuition schedule for courses:

MSMS members: \$5 per credit hour, or \$15 for each half-day course
Non-members: \$10 per credit hour, or \$30 for each half-day course
Residents: \$5 PER COURSE

Luncheon reservations: The hotel will provide luncheon each noon at \$8 per person. Advance reservations are requested so MSMS can give an accurate guarantee. Please indicate which days you want a lunch ticket.

- Tuesday lunch _____ Wednesday lunch _____ Thursday lunch _____
- Indicate total number of half-day courses: _____ × \$15 (members) \$ _____
_____ × \$30 (non-members) \$ _____
_____ × \$5 (residents) \$ _____
- Number of luncheons requested: _____ × \$8 \$ _____
- Registration for special 16-hr. ACLS Course (\$175 incl. lunch): \$ _____
- Total \$ _____

Make checks payable to MSMS and mail to MSMS, Box 950, East Lansing, MI 48823

The Republicans convened in Detroit; Michigan MDs were part of the show

By Willah Weddon, special to Michigan Medicine



Alternate delegates Richard E. Straith, MD, Southfield, and Sue Willison, wife of Charles H. Willison, MD, Midland, seated during convention deliberations.

Michigan's medical community was there when the country's Republicans held their mid-July national convention in Detroit.

Physicians, their families and colleagues served as alternate delegates and volunteers, worked hard, had a good time and enjoyed seeing a little history made.

Alternate delegates included Richard E. Straith, MD, Southfield; Sue Willison, wife of Charles H. Willison, MD, Midland; and Harriet A. Rotter, wife of Norman J. Rotter, MD, Huntington Woods. When their respective counterparts were not on the floor of the Joe Louis Arena, they filled in for them.

Frank M. Ochberg, MD, Director of Michigan's Department of Mental Health, also spent some time on the area floor as a "security" guard. Although the convention ran about as smoothly as could be expected for

any gathering of approximately 22,000, Doctor Ochberg's knowledge in crowd behavior had been sought in preparing police for the event.

Nell Rhoades, wife of Francis P. Rhoades, MD, was among Detroiters who volunteered months ago to assist during the convention. Doctor Rhoades was one of 20 physicians or groups in the Wayne County Medical Society who had volunteered their services for a 24 hour referral center.

The WCMS ordinarily conducts an answering service from 8:30 AM to 5 PM daily with a regular roster of physicians for referral. The additional volunteers enabled them to provide the service around-the-clock. People who needed to see a physician but were not considered emergency cases could be given appointments without waiting under this arrangement.

The medical facilities on the

scene were more complex and took care of problems ranging from at least two heart attacks to less serious injuries suffered in the Arena. One of the latter occurred when a delegate from Garnett, Kansas, was instilled with a great desire to dance upon her chair during the nomination of Ronald Reagan as Republican Presidential candidate.

Her enthusiasm gave way to dismay when she fell off the chair and injured her ankle. Paramedics were at her side in minutes. (She refused to leave, however, until the nomination had been completed.)

If immediate medical attention had been necessary, the woman would have been taken to the on-site aid station at the east end of the Joe Louis Arena. Here an emergency-trained physician and nurse were on duty during every session. (A similar aid station also was active in Cobo Hall.) If patients needed hospitalization, there was an Emergency Medical Service truck on standby outside the Arena to whisk them to local hospitals where special arrangements had been made for emergency staffs.

A second EMS truck also was on standby especially for the presidential and vice-presidential nominees.

Additional precautions had been taken by moving a large fire department bus, equipped as a makeshift hospital unit, to the arena's west gate. Staffed by a physician, nurse and paramedic, the bus contained a surgical table and other equipment necessary to handle emergencies occurring outside the arena.

Most of these arrangements had been made by the special team in Detroit, under Emergency Medical Service chief Dan Bojalad, and they were in effect during the week of the convention.

Television crews, which arrived previously, had brought their own first aid equipment and personnel with them.

Ruby Gordon, RN, of New York,

(continued on page 462)



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*Canadian Lakes
Member and Now
Traveling Club Pro*

We're proud to announce that Don Pohl is the club's traveling professional. Two time Michigan Amateur champ, Dan is the hottest new-comer on the PGA circuit. He's the leading straight hitter and among the top money winners.



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NAME			
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PHONE NUMBER		MM-9	



Harriet Rotter, Huntington Woods, wife of Norman J. Rotter, MD, joins in the fun as a member of the Michigan Civil Service Commission.

for instance, had come to Detroit two weeks prior to the convention and manned the first aid room for CBS. With a crew of 900 people, she was on duty from 9 AM until 7 PM until the convention opened and then she worked until each evening's session concluded.

When a serious illness needed attention, she called a hospital which had agreed to assist her.

Ms. Gordon expected to stay about three or four days after the convention while the television crew tore down the equipment to move back to New York.

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Scored Tablets

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is now
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(diethylpropion hydrochloride NF)

Tenuate Dospan®

(diethylpropion hydrochloride NF) controlled-release

AVAILABLE ONLY ON PRESCRIPTION

Brief Summary

INDICATION: Tenuate and Tenuate Ospan are indicated in the management of exogenous obesity as a short-term adjunct (a few weeks) in a regimen of weight reduction based on caloric restriction. The limited usefulness of agents of this class should be measured against possible risk factors inherent in their use such as those described below.

CONTRAINDICATIONS: Advanced arteriosclerosis, hyperthyroidism, known hypersensitivity or idiosyncrasy to the sympathomimetic amines, glaucoma. Agitated states. Patients with a history of drug abuse. During or within 14 days following the administration of monoamine oxidase inhibitors, (hypertensive crises may result).

WARNINGS: If tolerance develops, the recommended dose should not be exceeded in an attempt to increase the effect, rather, the drug should be discontinued. Tenuate may impair the ability of the patient to engage in potentially hazardous activities such as operating machinery or driving a motor vehicle, the patient should therefore be cautioned accordingly. *Drug Dependence:* Tenuate has some chemical and pharmacologic similarities to the amphetamines and other related stimulant drugs that have been extensively abused. There have been reports of subjects becoming psychologically dependent on diethylpropion. The possibility of abuse should be kept in mind when evaluating the desirability of including a drug as part of a weight reduction program. Abuse of amphetamines and related drugs may be associated with varying degrees of psychologic dependence and social dysfunction which, in the case of certain drugs, may be severe. There are reports of patients who have increased the dosage to many times that recommended. Abrupt cessation following prolonged high dosage administration results in extreme fatigue and mental depression, changes are also noted on the sleep EEG. Manifestations of chronic intoxication with anorectic drugs include severe dermatoses, marked insomnia, irritability, hyperactivity, and personality changes. The most severe manifestation of chronic intoxications is psychosis, often clinically indistinguishable from schizophrenia. *Use in Pregnancy:* Although rat and human reproductive studies have not indicated adverse effects, the use of Tenuate by women who are pregnant or may become pregnant requires that the potential benefits be weighed against the potential risks. *Use in Children:* Tenuate is not recommended for use in children under 12 years of age.

PRECAUTIONS: Caution is to be exercised in prescribing Tenuate for patients with hypertension or with symptomatic cardiovascular disease, including arrhythmias. Tenuate should not be administered to patients with severe hypertension. Insulin requirements in diabetes mellitus may be altered in association with the use of Tenuate and the concomitant dietary regimen. Tenuate may decrease the hypotensive effect of guanethidine. The least amount feasible should be prescribed or dispensed at one time in order to minimize the possibility of overdosage. Reports suggest that Tenuate may increase convulsions in some epileptics. Therefore, epileptics receiving Tenuate should be carefully monitored. Titration of dose or discontinuance of Tenuate may be necessary.

ADVERSE REACTIONS: *Cardiovascular:* Palpitation, tachycardia, elevation of blood pressure, precordial pain, arrhythmia. One published report described T-wave changes in the ECG of a healthy young male after ingestion of diethylpropion hydrochloride. *Central Nervous System:* Overstimulation, nervousness, restlessness, dizziness, jitteriness, insomnia, anxiety, euphoria, depression, dysphoria, tremor, dyskinesia, mydriasis, drowsiness, malaise, headache; rarely psychotic episodes at recommended doses. In a few epileptics an increase in convulsive episodes has been reported. *Gastrointestinal:* Dryness of the mouth, unpleasant taste, nausea, vomiting, abdominal discomfort, diarrhea, constipation, other gastrointestinal disturbances. *Allergic:* Urticaria, rash, ecchymosis, erythema. *Endocrine:* Impotence, changes in libido, gynecomastia, menstrual upset. *Hematopoietic System:* Bone marrow depression, agranulocytosis, leukopenia. *Miscellaneous:* A variety of miscellaneous adverse reactions has been reported by physicians. These include complaints such as dyspnea, hair loss, muscle pain, dysuria, increased sweating, and polyuria.

DOSAGE AND ADMINISTRATION: Tenuate (diethylpropion hydrochloride): One 25 mg tablet three times daily, one hour before meals, and in mid-evening if desired to overcome night hunger. Tenuate Ospan (diethylpropion hydrochloride) controlled-release: One 75 mg tablet daily swallowed whole, in mid-morning. Tenuate is not recommended for use in children under 12 years of age.

OVERDOSAGE: Manifestations of acute overdosage include restlessness, tremor, hyperreflexia, rapid respiration, confusion, assaultiveness, hallucinations, panic states. Fatigue and depression usually follow the central stimulation. Cardiovascular effects include arrhythmias, hypertension or hypotension and circulatory collapse. Gastrointestinal symptoms include nausea, vomiting, diarrhea, and abdominal cramps. Overdose of pharmacologically similar compounds has resulted in fatal poisoning, usually terminating in convulsions and coma. Management of acute Tenuate intoxication is largely symptomatic and includes lavage and sedation with a barbiturate. Experience with hemodialysis or peritoneal dialysis is inadequate to permit recommendation in this regard. Intravenous phentolamine (Regitine®) has been suggested on pharmacologic grounds for possible acute, severe hypertension, if this complicates Tenuate overdosage.

Product Information as of April, 1976

MERRELL-NATIONAL LABORATORIES Inc.

Cayey, Puerto Rico 00633

Direct Medical Inquiries to

MERRELL-NATIONAL LABORATORIES

Division of Richardson-Merrell Inc.

Cincinnati, Ohio 45215, U.S.A.

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References: 1. Citations available on request from Medical Research Department, MERRELL-NATIONAL LABORATORIES, Cincinnati, Ohio 45215. 2. Hoekenga, M.T., O'Drillon [Oillon], R.H., and Leyland, H.M. A comprehensive review of diethylpropion hydrochloride. In: *Central Mechanisms of Anorectic Drugs*, S. Garattini and R. Samanin, Ed., New York, Raven Press, 1978, pp 391-404.

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**Overweight may not always be simple...
complications can develop*.
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Tenuate[®] Dospan[®] ^{IV} **(diethylpropion hydrochloride NF)** **75 mg. controlled-release tablets**

A useful short-term adjunct in an indicated weight loss program.

Overweight patients in certain diagnostic categories often require strict appetite control and a successful program of weight reduction may tend to diminish the incidence or severity of the complications in some patients. Diethylpropion hydrochloride has been reported useful in such patients and while it is not suggested that Tenuate itself in any way reduces the complications of overweight, it may have a useful place as a short-term adjunct in a prescribed dietary regimen. **Tenuate should not be administered to patients with severe hypertension; see additional Warnings and Precautions on the opposite page.**

In uncomplicated overweight.

Many patients, on the other hand, present with excess fat but no disease. While this condition is often termed uncomplicated obesity, complications of both a social and a psychologic nature may be distressingly real for the patients. In these cases, a short-term regimen of Tenuate can help reinforce your dietary counsel during the important early weeks of an indicated weight loss program.

Clinical effectiveness.

The anorectic effectiveness of diethylpropion hydrochloride is well documented. No less than 16 separate double-blind, placebo-controlled studies attest to its usefulness in daily practice.¹ And the unique chemistry of Tenuate provides "...anorectic potency with minimal overt central nervous system or cardiovascular stimulation."² Compared with the amphetamines, diethylpropion has minimal potential for abuse.

**Tenuate—it makes sense.
And it's responsible medicine.**

*Studies have shown that obesity is associated with an increased incidence of hypertension, symptomatic heart disease, adult-onset diabetes, and other diseases.

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For prescribing information see opposite page

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Each capsule contains
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and irritable bowel syndrome*

Librax[®]

Please consult complete prescribing information, a summary of which follows:

Indications: Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:

"Possibly" effective: as adjunctive therapy in the treatment of peptic ulcer and in the treatment of the irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis.

Final classification of the less-than-effective indications requires further investigation.

Contraindications: Glaucoma, prostatic hypertrophy, benign bladder neck obstruction, hypersensitivity to chlordiazepoxide HCl and/or clidinium Bromide.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants, and against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Physical and psychological dependence rarely reported on recommended doses, but use caution in administering Librax[®] (chlordiazepoxide HCl/Roche) to known addicts.

tion-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions) reported following discontinuation of the drug.

Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy. Advise patients to discuss therapy if they intend to or do become pregnant.

As with all anticholinergics, inhibition of lactation may occur.

Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules/day initially, increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such as MAO inhibitors, phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions reported in psychiatric patients. Employ usual precautions in treating anxiety states with evidence of impending depression. Suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation reported very rarely in patients receiving the drug

and oral anticoagulants, causal relationship not established.

Adverse Reactions: No side effects or manifestations not seen with either compound alone reported with Librax. When chlordiazepoxide HCl is used alone, drowsiness, ataxia, confusion may occur, especially in elderly and debilitated, avoidable in most cases by proper dosage adjustment, but also occasionally observed at lower dosage ranges. Syncope reported in a few instances. Also encountered: isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent, generally controlled with dosage reduction; changes in EEG patterns may appear during and after treatment blood dyscrasias (including agranulocytosis), jaundice, hepatic dysfunction reported occasionally with chlordiazepoxide HCl, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax typical of anticholinergic agents, i.e., dryness of mouth, blurring of vision, urinary hesitancy, constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.

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Michigan hospitals assess recession's impact in confusing, contradicting variety of ways

By Dwight Angell, special to Michigan Medicine

According to conventional wisdom, bad economic times breed prosperous times for hospitals.

A number of studies show that during the half-dozen or so recessions since World War II, hospital utilization increased. The reasoning is rather simple: when a person is laid off, the health care benefits will be covered for a period of time (certainly in heavily unionized states like Michigan). The time varies according to job seniority, but can be up to one year. So the worker, with the time available, may decide to undergo an elective medical procedure that he was putting off when he was working and didn't have the time.

At the same time, the stresses and strains of unemployment manifested in increased psychological problems are well-documented: more domestic violence, mental problems, alcoholism and drug abuse. And most are reflected in higher patient visits at hospitals.

That's the conventional line.

In the state of Michigan, with the nation's highest rate of unemployment, with some cities like Flint hitting depression-level figures for unemployed, it would follow that hospitals are booming.

But that is not so.

No significant changes

According to a random survey by Michigan Medicine of a dozen hospitals throughout the state, most do not report any significant changes in normal operations to date that can be directly attributed to the recession. Those hospitals in areas with automotive industries do report some recession-related changes and several hospitals anticipate things getting worse.

No hospital contacted is anticipating a long-term recession. Should a protracted economic downturn develop, however, hospitals could have entirely different experiences. The situation will become clearer as the months go by.

The out-state hospitals, so far, appear almost isolated from the



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downturn in the economy. Marquette General Hospital in the Upper Peninsula reports surgery and the patient load are up, but can't relate those trends to the economy. Besides, the local economy is not tied to the automobile, but to mining. Three years ago, a local strike, lasting about four months, produced an increased utilization at the hospital. This June there were lay-offs of 2,000 workers at the local mining company, but the hospital hasn't felt any impact and is not sure that it will.

At Traverse City's Munson Medical Center, business has never been better, says Frank Moss, vice president of finance. "There is no depression or recession or anything in our building." In fact, the hospital has hired six additional physicians in the last half year.

But he says their growth is related to the population growth of that region, the fastest in the state. Mr.

Moss says part of the increased utilization is due to laid-off workers seeking medical care while their benefits last. But the lay-offs are small. For one thing, he says, the largest employer for the five-county area is Munson Medical Center itself. And Munson is not laying off; it is hiring.

Unemployment high

In Battle Creek, in Western Michigan, unemployment is running high, almost 12 percent. (According to the Michigan Employment Security Commission, unemployment for the entire state in July was 14.1 percent; for the City of Detroit, it's 18.3 percent.) But Daniel Muenzer, executive vice president of the 228-bed acute-care Leila Hospital and Health Center, is not planning on or anticipating a long term recession. The hospital's patient load is lighter, but that trend has been noticed for sev-

(continued on page 468)

must What you ~~should~~ know about the Michigan Drug Substitution law

The state legislature has dramatically changed the lawful way of prescribing drugs and of writing a prescription. Until now, writing the brand name of a drug on the prescription was enough to ensure that the brand-name drug would

indeed be dispensed. Now that no longer suffices. Unless the physician takes the necessary extra steps, for many drugs the pharmacist may substitute an "equivalent" generic drug.

Key points for the physician in writing prescriptions

- The pharmacist shall not dispense a generically equivalent drug product if:
 - (a) The prescriber, in the case of a prescription in writing signed by the prescriber, writes in his own handwriting "dispense as written" or "D.A.W." on the prescription.
 - (b) The prescriber, having pre-printed on his prescription blanks the statement "another brand of a generically equivalent product, identical in dosage, form, and content of active ingredients, may be dispensed unless initialed "D.A.W.", writes the initials "D.A.W." in a space, box, or square adjacent to such statement.
 - (c) The prescriber, in the case of a prescription other than one in writing signed by the prescriber, expressly indicates the prescription is to be dispensed as communicated.

Rx

D.A.W.

Signature

The decisions the physician must make

The physician should acquaint himself with the newly mandated prescription language illustrated on the preceding page. This requires a distinct change from the way prescriptions were previously written.

The prescription may be filled generically unless the physician writes in his own handwriting "D.A.W." or "Dispense As Written." Only by adding this language can the physician ensure that the brand-name drug will be dispensed.

If the physician elects to permit substitution, no special indication need be made, since unless explicitly prohibited the pharmacist may substitute.

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RECESSION/continued

eral years. The hospital is experiencing more Medicaid patients, an indicator of a weak economy.

Lansing's Sparrow Hospital is noticing an increase in its emergency and outpatient facilities use. But the feeling there is that the increase is not related to the economy but to other factors.

Flint and Saginaw are cities where the economy is directly dependent upon the auto business. Both cities have been hit with depression unemployment figures. The MESC says for the month of June, 23.1 percent, or 54,700 individuals, were out of work in Flint. The average figure across the country at the worst point in the Great Depression was 25 percent.

Saginaw General Hospital personnel report no real increase in cases stemming from violence or the psychological problems noted earlier in this article. Numbers of Medicaid patients are up slightly. The hospital feels that most of the laid-off General Motors workers still are drawing their Supplemental Unemployment Benefits (SUB), but these are expected to run out soon. Says a hospital spokesman: "The next six months will be the crunch period."

Hurley Medical Center in Flint reports results similar to Saginaw's. Utilization is not up, but officials there expect to see a "dramatic impact" by the end of the year. The hospital is already experiencing an increase in unpaid medical bills.

Taking steps

One hospital in Ann Arbor has felt the impact of the recession and is taking steps to handle it. William Fileti, associate administrator for St. Joseph Mercy Hospital, says the hospital had an employee study the effects of the 1974-75 recession. That report concluded that hospitals are not affected by a recession although they tend to have an increase in patients with problems related to mental stresses and strains.

Within the next several months St. Joseph Mercy will add a mental health program which will include a social worker, psychiatric nurse and a psychiatrist. This is because the hospital has begun to see an increase in psychologically-related problems. The report, therefore, confirmed what

the hospital was already experiencing earlier in the year.

"Nevertheless," says Fileti, "it's too early to judge the impact of the recession because of counter-balancing forces." The two forces are laid-off individuals who have the health care benefits and use them; at the same time, there are laid-off individuals with no health care benefits, and these individuals will not seek treatment.

In the Detroit area, with one exception, all hospitals surveyed show some signs that the recession is having an impact.

Detroit Memorial Hospital in downtown Detroit reports that there has been a 10 percent increase in the last year in use of its mental health and alcoholism units.

North Detroit General Hospital, says associate administrator Jerry Frohlich, is seeing some signs of a depressed economy. "A lot more people are coming in who are cash patients." But there has been no increase in Medicaid patients or patients with psycho-social related problems." Says Frohlich, "we are anticipating things to get worse. Fortunately we haven't seen them yet."

In suburban Royal Oak, William Beaumont Hospital reports that the patient load is heavier and outpatient surgery is up 13.5 percent for the month of June 1980 compared to June 1979.

Trester also reports that, although emergency room visits are up, they are not due to psycho-social stresses. Rather, patients apparently are by-passing their doctor's office, which Blue Cross-Blue Shield will not pay for, and instead heading to the emergency room where there is a greater likelihood the Blues will cover medical care.

Yet, if you travel to the east side of Detroit, to St. John Hospital, the story is completely different. Glenn Wesselmann, executive vice-president, maintains that though activity is higher than ever, he can't say for certain it's related to the economy. And though he calls the service area of the hospital "Chrysler Country," the hospital hasn't seen any increases in Medicaid or cash-paying patients.

Henry Ford Hospital is seeing a lower percent of Blue Cross-Blue Shield patients and more private pay and Medicaid patients. And interest-

ingly enough, although Ford is going ahead with projects on the drawing board, says a spokesperson, the hospital is delaying or slowing down major capital expenditures.

If there appear to be some contradictions in reports from hospitals, then the overall picture is even more confusing.

For example, the Michigan Hospital Association has data from two different surveys of Michigan hospitals for bed occupancy. One says that there is no increase, and the other says that bed occupancy is up 2.9 percent in the last year.

Nevertheless, MHA considers hospitals recession-proof; patient load remains about the same or increases.

Postponing decisions

Since hospitals are not reporting increases in patient load yet, Ken Raske of the MHA has developed a theory about what is happening. (MHA, says Raske, has not received inquiries from hospitals about the recession.)

It is his belief that this recession is not cyclical, but rather structural — that some jobs in the auto industry will be lost forever. And, says Raske, the by-product of that is a high degree of uncertainty among the unemployed, an uncertainty that permeates all decision-making by the heads of households. "In a time of uncertainty in economic times, people just don't make decisions of any kind. They postpone them."

The potential problems for hospitals, he believes, will come from the same third party insurance institutions that for years have insulated the hospitals. The state Medicaid budget for the next fiscal year is in jeopardy, with a strong proposal of a five percent reduction of payments to hospitals.

"And the Blues are not insulated when their major contributors are the auto companies," says Raske.

"If these purchasers are deteriorating over a long period of time, becoming less solvent or even insolvent, then the Michigan health care industry is in jeopardy."

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MSMS 'China Adventure' group can get some travel tips here

By Sander J. Breiner, MD Birmingham



Everybody wanted a look at the American tourists, reports Doctor Breiner. This crowd gathered around his bus is a typical example of the interest shown in Americans. (The MSMS China Adventure is scheduled Sept. 10-29.)

For all the Michigan physicians who will be taking the MSMS China Adventure this fall, and others planning a tour of China soon, here are some tips that may be helpful, and which I garnered on my recent trip to China.

Weather

Northern China's weather during the cold months (November through March) is harsher than temperature charts indicate. The March weather we encountered was much like winter in the Texas or Oklahoma Panhandles. Daytime temperatures in Peking were around 40° to 45°F.

However, there are other factors — the wind and the dust. The wind blows almost constantly, so the wind-chill factor makes the effective temperature much colder. Except for hotels and parts of hospitals, most buildings are poorly heated or not heated at all, with the result that we had difficulty warming up. MSMS travelers should find 10° warmer weather, on the average, in September.

Then there's the dust. The soil of northern China, where there is only about 15 inches of rain yearly, is a fine, powdery, clay-like soil with

properties not unlike talcum powder. It is almost invisible when blowing, but it gets into everything, and there is a fine layer everywhere. Cuffs, shirts and collars will get dirty; it will be in the drawers in the hotel room.

More significantly for the tourist, the dust gets into the nose and the lungs. Persons coming from more humid areas will find that lips and the lining of the nose and throat begin to crack and dry almost immediately.

It is likely, especially for those people with minor, symptomless respiratory infections, that the irritation of this inhaled powdery soil will precipitate bronchitis, laryngitis, or even pneumonia. It is not uncommon for the tourist to pick up a cough, and become ill. The best preventative for this is to take medication such as Vibramycin during the entire trip. One hundred milligrams a day is a usual dosage.

It also is a good idea to bring some facial tissue, an amenity not commonly found in China (the Chinese use the ubiquitous spittoons for clearing their noses as well as their throats). This tissue can be used as bathroom tissue also if one finds, as many will, that the crepe-paper-

like substance provided in Chinese bathrooms is simply too rough for comfort.

Clothing

The Chinese themselves dress very casually by our standards. Suits and ties and dresses are not very practical; slacks are best for both men and women.

The remainder of the wardrobe should consist of sweaters and a padded jacket or a windbreaker. Women should wear loose clothing, especially avoiding girdles, when going out of the hotel — Chinese style toilets, often no more than a hole requiring a deep squat, present a real challenge to a woman in tight-fitting clothing.

Accommodations

The Chinese being the hospitable people that they are, it is not surprising that they reserve their best accommodations for their guests. The finest, newest buses are the tour buses; the finest hotels with the finest food and service in all of China are what the tourist gets.

But a word of caution: though they are the best in China, the hotels do not compare with high-quality places in America and Europe. They are not well-maintained and, because of the dust, they don't have that spotless quality that Westerners are accustomed to, and may have a somewhat shabby look.

Cockroaches are everywhere, including in the hotel rooms. I wished, from time to time, that I had a can of insect spray when the traffic got a little heavy.

There may not be a shower in the hotel room, but there will be a Western-style flush toilet, a bath tub, and running hot and cold water. Most hotels have a laundry service, which does laundry promptly. There are also sufficient towels, though they won't be replaced with clean ones except on request.

There are certain items in each hotel room: a large thermos of hot tea, or hot water for tea, with cups; fruit, usually apples and pears; and bottles of orange pop and beer. None of these items are extra, but are included in the price of the room. The fruits, though the Chinese are very

(continued on page 472)

DESCRIPTION: Methyltestosterone is 17 β -Hydroxy-17-Methylandrosterone-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male; 1. Eunuchoidism and eunichism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-puberal cryptorchidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric,

avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE**

REACTIONS: Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. **In the male:** Eunuchoidism and eunichism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpuberal cryptorchidism, 30 mg. **REFERENCE:** R. B. Greenblatt, M.D.; R. Witherington, M.D.; I. B. Sipahioglu, M.D. Hormones for Improved Sexuality in the Male and the Female Climacteric. *Drug Therapy*, Sept. 1976. **SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only.

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CHINA/continued

proud of them, are not as good as those we are used to getting in America.

Our hotel rooms were never locked, which is an indication of the absolute honesty of the Chinese people; they are the most honest people I have ever run across.

Food

The food was a highlight of our trip. We usually had an American-type breakfast, and ate Chinese-style lunches and dinners. A couple of times, though, we had Chinese breakfasts, and they turned out to be well worth our while. They are much grander than the standard Western bacon-and-eggs fare: there are various dumplings, pastry, soups, noodles, and, of course, rice.

Lunch and dinner would often approach banquet proportions. There are many different courses for each meal; they come rapidly and in large amounts, and they are delicious. Even the box lunch we had on the train to the Great Wall was one of the grandest box lunches ever — pressed duck, cold cuts, eggs, fruit, cookies, bread, butter, and more. I never had finer Chinese meals in my life than those in China (which is to be expected, I guess).

Public transportation and shopping

If one wishes to travel separately from the group, to see some places himself, he simply walks. It is not advisable to take the public buses, because they are very crowded, and one probably couldn't understand where they are going without knowing Chinese (and even then the bus system can be confusing, just as it can be in an unfamiliar American or European city).

There are taxis, but they are not readily available. They cannot be flagged down, but must be ordered from the hotel. The taxi driver has to be told by an interpreter where the tourist is going and why. There are some places where the tourist is discouraged from going without specific permission, such as government installations. The taxi drivers will, however, gladly take people to a Friendship Store or other shopping establishment where English is spoken. (These Friendship Stores, geared

to tourists, are set up with the finest and, often, most expensive items. The Peking Friendship Store will ship items out of the country, though those in other cities will not at the present.)

The days of great bargains in Chinese jade and antiques are gone. The Chinese have learned what prices are on the world market, and they charge top dollar for their antiques and art objects. Also, one cannot be certain, unless expert, of getting an authentic antique. I don't believe the Chinese would knowingly cheat a tourist, but often they do not know what is a genuine antique and what is not.

There are, perhaps, still some bargains in some paintings and embroidery work.

Communication

Everyone in China seems to be trying to learn English. The more educated people — those who have gone at least as far as high school — have had some English training, and those who have gone on to a university often can read and write English fairly well. However, they haven't had native speakers to teach them pronunciation, so they often don't know what English sounds like and can't pronounce it properly. So they practice on foreigners constantly.

The new Chinese interest in the West extends beyond learning the language. The Westerner, with his strange eyes, complexion, hair, beard, and unusually-colored attire, is an object of great curiosity and interest to the Chinese people. One gets to feel somewhat like the new giraffe in the zoo; he is such a strange-looking creature, everybody wants to have a look at him.

And look they do. We felt like celebrities, with dozens, even hundreds of people following and crowding around us. They aren't hostile; just interested, and curious.

Guides

Tourists are supplied with English-speaking guides for the entire trip. There not only are guides who accompany each group in each city (25 — 24 plus the guide seems to be the standard-size tour), but, there also is a guide from the national tour agency who accompanies the group for the entire trip. These guides are

very kind, thoughtful and considerate in the care they give the tourist.

The Chinese guides are constantly trying to understand Americans, who seem to be the most difficult nationality for them to comprehend. There is little understanding of the nuances of our humor, especially the American tendency to kid, to joke and tease.

Also, though we considered our group to be rather tightly-knit and conforming, by their standards we were so loosely organized that we could hardly be called a group. The US prizes its individuality, but this is not really understood by the Chinese.

The guides and the personnel in the various establishments often said, "Please criticize us," as "you in America and the West have so much technology, and are so knowledgeable; we in China are so backwards, but we are trying hard to catch up to you."

We learned that an understanding of what they are asking for, and a careful response, are important. They don't want to be told what we don't like about what they're doing; they want to be offered information that could be useful to them. It is especially not good form to tell them how much more we have in terms of material things, which will make them, quite naturally, defensive. However, they do want to know about the people in our country, and, like anyone, they like to be told how much they are appreciated for the things they have done.

Conclusion

As I sat in the plane that was to bring me back to the West, I had the opportunity to reflect on my experiences and impressions. The people are wonderful, warm, charming, and interesting, and it was one of the most fascinating trips of my life; but it was not all tea and comfort.

It was well that I had prepared myself for the trip, as that greatly enhanced my enjoyment.

The tourist who takes the trouble to find out a bit about the country and to learn a few basic phrases in Chinese need have no fears about traveling in China, and should have as fascinating a time as I had.

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They're in their late sixties, the beneficiaries of more liberal retirement laws and more enlightened attitudes toward the elderly. They're leading socially productive lives. But recently, without any clear cause, they had each begun to experience mild episodes of symptoms such as confusion, mood-depression, and dizziness. Their ability to function could have been jeopardized. That's when they became the beneficiaries of oral Hydergine therapy.



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Indochinese refugees' cultural traditions often their only link to past



The Vietnamese way of life was maintained with great difficulty by refugees crowded into camps on the Thailand-Cambodia border. Now they face the difficulties of adapting to the very foreign North American way of life.

The following article is excerpted from reports by the Indochinese Education Project, Lansing Community College.

In recent years many Americans have been absorbed in finding their "roots." Yet recent immigrants, including refugees, are encouraged to abandon their native cultural practices and adopt the "American Way of Life."

Indochinese refugees continue to resettle in Michigan, and physicians around the state are being called to assess their health care needs and take on their care. A recent survey of Michigan physicians in the *MSMS Medigram* newsletter brought responses from 80 Michigan physicians volunteering to care for the refugee families.

With this issue, we continue our series of articles devoted to helping Michigan physicians better understand the physical, and emotional plight of the Indochinese refugees and their health care needs.

Aside from the questionable value of that belief, a more basic consideration remains. Cultural influences are not easily purged. Since an individual's personality is largely influenced by the values and expectations of the environment, culture is a major force in shaping a person's view of life. For a refugee who has lost home, country, and loved ones, the intangible aspects of culture are the only link to the past.

Traditionally, Westerners have viewed Southeast Asia as culturally backward. Our terminology exemplifies our attitude: by lumping Vietnam, Cambodia and Laos under the term "Indochina," the individualities of each culture are lost. Yet Indochina is not culturally homogeneous, nor are the individual nations — Vietnam, Cambodia and Laos comprise a great cultural mosaic, a mosaic designed by the interaction and integration of many cultural forces.

Obviously there is little that can be done about the "culture shock" a refugee feels upon arriving in this country. A certain degree of culture shock is inevitable; however, even a moderate knowledge of the refugees' cultural and social characteristics will help service providers soften some of the effects of culture shock.

Vietnam

The Vietnamese people take great pride in their civilization and its 4,000-year history characterized by independence and freedom.

For the Vietnamese there are four broad categories of values: religious or spiritual, educational, familial and humanitarian. These broad categories all hinge on the central value that in all matters, personal or self-interest should be a secondary consideration.

Religion

For many centuries Buddhism has been the predominant religion in Vietnam. Having a strong impact on the culture are Buddhism's Four Noble Truths:

1. Man was born to suffer.
2. Craving is the cause of all suffering.
3. The only cure for craving is to detach oneself from all things, including self.
4. To achieve holiness one must take the eight-fold path: right conduct; right effort; right intentions; right livelihood; right meditations; right mindfulness; right speech; and right views.

Although Catholicism was only recently introduced in Vietnam its

fluence has been strong. Less than 10 percent of the population of South Vietnam was Catholic, but the Catholic Church was one of the best organized educational institutions in the country.

In addition, many of the Vietnamese believe in animism — the existence of spirits. According to animism, there are spirits of nature in water and wind, and most importantly, spirits of the dead wandering among the living.

Education

Education always has been extremely important to the Vietnamese, and educated people traditionally have been esteemed and honored.

The modern Vietnamese educational system was largely patterned after traditional French systems. After Vietnam gained independence in 1945, the educational system was built on three principles: to be humanist, national and open-minded.

Vietnamese students may find the American educational system bewildering because its mode of learning is so radically different from the Vietnamese system. The traditional Vietnamese pedagogical method was rote learning based on lecture notes. Students were rarely given reading or research assignments.

Family

For most Vietnamese, the family is the center of life. In fact, it is fair to say the whole Vietnamese society is based on the solid structure of the family and the relationship between the living and the dead. In Vietnam, family roles were more numerous, but much more sharply defined than in America. The most important operating rule for Vietnamese families was and still is) that each individual family member comes second to the family as a whole.

The Vietnamese father is viewed by all as the head of the household. He makes all important family decisions, and his wife and children treat him with respect.

The mother's life should reflect the theme of harmony. Early in life Vietnamese girls are taught that a woman's beauty is judged by her virtue rather than her appearance. Traditionally a good woman has four qualities: 1) she is good at needlework and housework; 2) she has a

feminine appearance; 3) she must speak softly and choose her words carefully; and 4) she must show a good example and act virtuously.

In addition, women must learn and follow the Three Obediences: 1) before marriage women must obey and respect their fathers; 2) after marriage women must obey and respect their husbands; and 3) at widowhood women must obey and respect their sons.

Large families are common and boys are preferred. The strongest family ties are between parent and child, rather than between spouses. Children are highly valued; not only do they carry on the family name but also they care for their parents in old age. In fact children are taught that they owe their parents a debt for their birth and rearing, and that debt is repaid by being loyal and supportive. Old age homes were practically nonexistent in Vietnam, because children brought their parents to live in their household.

Vietnamese children are generally polite and somewhat reserved. Children are strictly disciplined, and disobedience to the parents is a very serious matter. Children are expected to help with household chores and the care of younger brothers and sisters.

Personal characteristics

Generally speaking, the Vietnamese are polite and very conscious of the importance of good manners. In addition, they are a gentle people, who do not like to make their feelings publicly known except to their most intimate friends.

Unlike Americans, the Vietnamese do not always consider reason more important than emotion. Feelings and emotions are of paramount importance, and sensitivity is viewed as a quality for which all should strive.

Not surprisingly, the Vietnamese concept of time is not rigid. Punctuality (like rationality) has no intrinsic value; it has value only when applied in practice.

There are two main language families represented in Southeast Asia: Tai and Austro-Asiatic. Vietnamese, the predominant language of Vietnam, falls in the latter group.

The spoken Vietnamese language is primarily monosyllabic. It is

a tonal language, which when written, uses diacritical marks with vowels to indicate the appropriate tone. Using the proper tone is of utmost importance, because inaccurate intonation can result in a completely different word. The number of tones varies between dialects, but normally there are four to six tones.

A new life

Generalizations about cultural traditions and values must be tempered with the fact that each and every individual in a society internalizes those values in a unique way. Even the strongest social mores and customs cannot remain unaffected by change.

While highlights of the traditional Vietnamese culture have been presented, it would be one-sided not to mention a factor which has deeply challenged those traditions.

Obviously, the effects of war were the strongest force challenging Vietnamese values. Although statistical estimates tell only a partial story, they provide some basis for judgment. In the ten-year period of 1965 to 1975 roughly 1.7 million Vietnamese civilians were killed or wounded in the war. Most young men were drafted into the South Vietnamese Army or joined the insurgent forces. Family separation and the destruction of villages generated 10,270,000 refugees from 1965-1973 alone.

It is difficult to say what the long-range effects of the War and flight to the U.S. will have on the Vietnamese. For the older refugees, culture shock will be more severe; for the younger generation adaption will be smoother. There is no doubt though that the deep-rooted traditional values will continue to play an important role as the Vietnamese carve out their unique place in the montage of American society.

Malnutrition and its effects on human health; a primer

By Sugnichand Sukhani, MD, Pontiac

Malnutrition literally means bad nutrition, which includes both over- and under-nutrition. People in most of the developing and underdeveloped countries are affected by undernutrition, because of calorie deficient diets available to them.

An adult 25 years of age, working eight hours in temperate countries, requires about 3,200 calories per 24 hours. In a hot climate, the requirement is 10 to 20 percent less. The estimated consumption of some villagers in the tropics is 2,400 calories per day. Growing children, pregnant and nursing mothers require many more calories and are more vulnerable to food deficiency.

In addition to the calorie-deficient, unbalanced diet available to many of the Indochinese refugees, there are the added effects of bacterial and parasitic infections, which are so prevalent there because of poor hygiene, unhealthy environment and lack of safe water supply.

Breakdown of society from the impact of war has further played a major part in producing nutritional deficiencies in Indochinese refugees.

Nutritional deficiencies which occur most commonly in the tropics are: (1) Protein calorie malnutrition: kwashiorkor, marasmus, marasmic kwashiorkor; (2) Vitamin A deficiency: xerophthalmia and keratomalacia; (3) Vitamin B deficiency: Beri-beri; (4) Vitamin B₂ deficiency:

Pellagra and ariboflavinosis; (5) Nutritional neuropathies.

Other deficiencies not so common are: (1) Vitamin C deficiency (scurvy); (2) Vitamin D deficiency (rickets); (3) Iodine deficiency (goiter).

As physicians here will be treating Indochinese refugees, they should be aware of signs and symptoms of some of the common nutritional problems.

Kwashiorkor

Kwashiorkor is the result of a diet low in protein, but sufficient in calories. It is a disease of artificially-fed or weaned infants and is not usually found in adults. Clinical features are growth failure, edema, skin lesions, hair changes, mental changes and diarrhea.

In treating these children, protein should be provided at three to five grams per kilogram of body weight, and diet provided giving 120 to 140 calories per kilogram per day. Potassium supplements should be given. In carbohydrate intolerance cases, lactose free material should be provided.

Marasmus

Marasmus is due to starvation of small children. Children are fed a diet which is adequate qualitatively, but is grossly deficient in calories. Marasmus is more frequent in infants than older children, because they are growing more rapidly. Growth ceases and the infant utilizes the subcutaneous fat, and then the muscles. The infant is hungry and cries continuously. The child is extremely emaciated, the muscles are atrophic. Skin is thin, flaccid, and wrinkled. Typical face of the marasmic child looks like that of a very little old man.

In treating these children, diet should be balanced and be adequate for the apparent biological age, and higher in calories than would be required for normal child. 200 calories

per kilogram of body weight daily is needed.

Vitamin A deficiency

Night blindness is an early symptom of this deficiency. Conjunctivae become dry, wrinkled and opaque, known as xerophthalmia. A more advanced stage of the deficiency leads to involvement of cornea, known as keratomalacia. Cornea becomes soft, and excavations or ulcerations occur. Perforation follows and total destruction of the eye may result.

Severe deficiencies should be treated by parenteral Vitamin A injection. Foods rich in vitamin A, like carrots, milk products, leafy vegetables and egg yolks, should be advised.

Vitamin B₁ deficiency

Beri-beri in two forms, paralytic (dry beri-beri) and edematous (wet beri-beri) results due to this vitamin deficiency. In dry type beri-beri, gradual onset of weakness of lower limbs is followed by ataxia; there may be paresthesia with burning or tingling in the limbs. In wet beri-beri, there is high output right heart failure. There is generalized edema of arms, legs, hands and trunk, and face is puffy.

Specific treatment of beri-beri is thiamine.

Vitamin B₂ deficiency

Pellagra is a syndrome caused by deficiency of variety of specific factors, with nicotinic acid as most important. The cardinal signs of pellagra constitute the well known diagnostic triad "diarrhea, dermatitis and dementia."

The treatment consists of providing ample and balanced diet with good supplies of fresh meat, liver, milk, eggs and additional source of Vitamin B complex.

Ariboflavinosis is due to deficiency of riboflavin. Sore red lips, angular stomatitis and purplish raw tongue covered with granular enlarged papillae are common signs. It is quickly cured by administration of 2.5 mg of riboflavin daily.

There are many other nutritional deficiencies not so common, which should be kept in mind while examining Indochinese refugees and be treated adequately.

(more on page 478)

Doctor Sukhani is chief resident in the Combined Pediatric Residency Program of the Pontiac Affiliated Hospitals. He is a graduate of SMS Medical College, Jaipur, India, and did post-graduate work in pediatrics from the same college in 1970. After working as clinical tutor in pediatrics in India, he worked as acting consultant and honorary lecturer in pediatrics at University Teaching Hospital, Lusaka, Zambia, for three years.

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Hepatitis B, Indochinese refugees, and their importance for Michigan MDs

Governor Milliken's relief fund supplies dramatic mercy missions

Michigan physicians' contributions to the governor's Michigan Refugee Relief Fund were helping fund a dramatic "mercy mission" action to Cambodian refugee camps as this journal went to press.

The Fund's organizers sent truck convoys to four refugee camps along the Thailand-Cambodia border which have been cut off from supply lines because of heavy fighting. The four camps had no assistance of any kind previously.

The exact location of the camps was not to be revealed until after the missions were completed, because of the high level of fighting, the danger to workers and because the Vietnamese might seal off the border to prevent delivery of supplies.

The shipments were scheduled Aug. 21, 26, 29 and Sept. 4. A physician, three nurses, and one medical technician were to go with each convoy. Each shipment contained rice, salt, canned vegetables, canned meat, fish and clothing.

Governor Milliken formed the relief fund after personally visiting the refugee camps in Cambodia in November, 1979. Contributions may be made to Michigan Refugee Relief Fund, Box 55-316A, Detroit, MI 48255.

The following article is reprinted, with permission, from the *Oakland County Medical Society Bulletin*.

Preliminary data from screening of Indochinese refugees entering Canada indicate that a significant percentage of them are positive for hepatitis B surface antigen (HBsAg). Most such individuals are asymptomatic and carry the antigen chronically. The following summarizes CDC's assessment of the current situation with respect to hepatitis B in Indochinese refugees and provides recommendations for dealing with chronic HBsAg carriers.

Assuming a 0.3 percent prevalence of antigenemia in the U.S. population, there are about 600,000 chronic hepatitis B carriers in this country. The additional number of carriers expected among the Indochinese refugees would increase the pool of carriers in the United States by approximately 4 percent. Most refugees are arriving in family units. Many are immune to hepatitis B and pose no threat of transmitting the disease.

In general, therefore, any increased risk of transmitting hepatitis

B to the U.S. population is expected to be small. This risk can be minimized by proper care and management.

Transmission of Hepatitis B

Hepatitis B virus (HBV) is found in blood and serous body fluids. Transmission is also possible via saliva and semen, but the relative efficiency of such transmission has not yet been determined. Most transmission is thought to occur — in situations of close or intimate contact — when infective blood or serous exudate enters the body of a susceptible person through a break in the skin or penetrates through a mucous membrane or the eye. Body fluids containing HBsAg can contaminate environmental surfaces, but there is no evidence that the virus can withstand routine cleaning, disinfection, or sterilization.

Thus, transmission is not likely to occur to school-age contacts of carrier children under normal hygienic circumstances or to social or work contacts of adult carriers. Neither is transmission likely to occur from carriers employed as food handlers or as hospital personnel, or from use of swimming pools, toilet facilities,

drinking fountains, restaurants, or other public facilities.

However, there is greater likelihood of transmission to neonates (during childbirth), to certain health-facility personnel, and to host families sponsoring orphans or refugee families with young children. While perinatal transmission and resultant chronic carriage is unusual in European and American populations, it is much more frequent in Asian populations studied. The neonate may acquire infection during delivery and thus would not be expected to excrete virus until several weeks later.

Dental personnel and oral surgeons are thought to be at some risk because they frequently sustain trauma to their hands while in contact with potentially infectious blood or saliva, which may also come in contact with their eyes and mucous membranes.

Recommendations

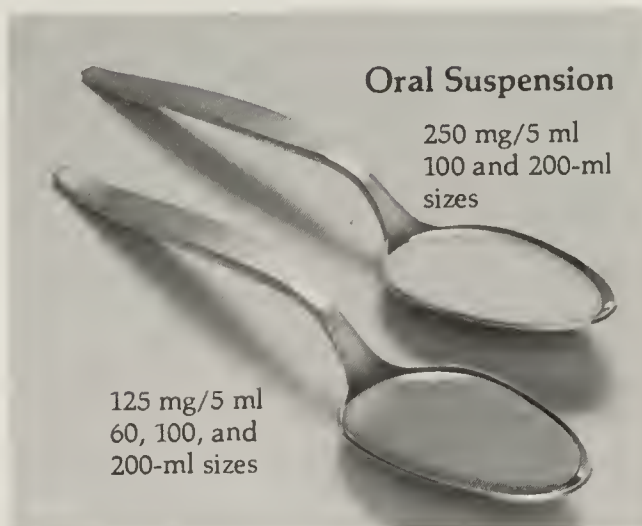
Determination of HBsAg Status: Testing for HBsAg and entering the result into the refugee's medical record should be part of the health as-

(continued on page 480)

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REFUGEES/continued

assessment or medical care of each Indochinese refugee after arrival in the United States. Among the refugees, priority groups for determination of HBsAg status, in descending order, would appear to be 1) women of childbearing age, especially pregnant women, 2) orphans, 3) preschool children and 4) other refugees. HBsAg positivity should not impede or preclude travel or placement of any individual. Nor should HBsAg testing be considered a substitute for reasonable, appropriate hygienic practices; refugees, host families, and medical and dental personnel should be encouraged to be mindful of both.

General: Thorough washing with soap or detergent and water is the most important measure that can be taken to eliminate the virus from contaminated environmental surfaces and from hands, after contact with a carrier. Spills of blood or other infectious material should be contained by cleaning with soap and water to remove any visible traces of the spilled material, followed by application of an appropriate disinfectant solution.

Carriers should not donate blood, and they should not share personal toiletries. Care should be taken to minimize breaks in the skin of carriers and their contacts. Items soiled by carriers' blood should be disposed of or washed promptly. Thorough dishwashing with hot soapy water or an electric dishwasher is adequate to decontaminate dishes. Routine laundering of clothes and linens is sufficient.

Certain persons and groups, particularly those involved in health care, are at greater risk than the general population of acquiring hepatitis B; this is because of occupational and environmental exposures. In the hospital setting the proper handling of blood and other body fluids of HBsAg carriers by hospital personnel is clearly indicated. To prevent possible exposure, dental personnel may want to consider wearing gloves, face masks, and eyeglasses when treating HBsAg carriers.

Prevention of perinatal transmission would be facilitated by prior knowledge of the HBsAg status of the mother. It is thus reasonable to deter-

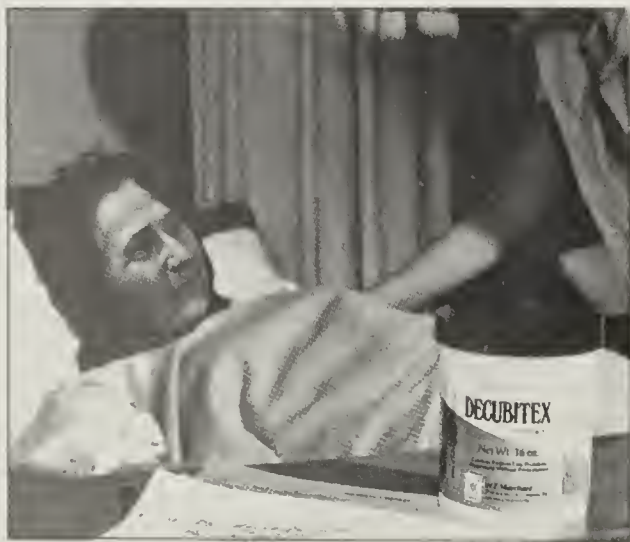
mine the antigen status of pregnant refugee women. After being thoroughly bathed, the neonate of a carrier mother need not be isolated. The neonate of a carrier mother should receive hepatitis B immune globulin (HBIG) — or immune serum globulin (ISG) if HBIG is not available — as soon as possible after birth, and certainly within 48 hours. Various dosages have been recommended.

It should be noted that the foregoing general recommendations apply not only in the management of HBsAg-positive Indochinese carriers, but also in the management of all HBsAg carriers and in the prevention of transmission of hepatitis B. Hepatitis B Immune globulin (HBIG) and Immune Serum Globulin (ISG): Immunoglobulins HBIG and ISG may be effective when used promptly after acute, percutaneous exposure. Recommendations of the public Health Service Advisory Committee on Immunization practices regarding immune globulins for protection against viral hepatitis were recently published in the MMWR.

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EQUAGESIC—Abbreviated Summary

***INDICATIONS:** Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FOA has classified the indications as follows:

"Possibly" effective for the treatment of pain accompanied by tension and/or anxiety in patients with musculoskeletal disease or tension headache.

Final classification of the less-than-effective indications requires further investigation.

The effectiveness of Equagesic in long-term use, i.e. more than four months, has not been assessed by systematic clinical studies. The physician should periodically reassess usefulness of the drug for the individual patient.

CONTRAINDICATIONS: Equagesic should not be given to individuals with a history of sensitivity or severe intolerance to aspirin, meprobamate, or ethoheptazine citrate.

WARNINGS: Careful supervision of dose and amounts prescribed for patients is advised, especially with those patients with known propensity for taking excessive quantities of drugs. Excessive and prolonged use in susceptible persons, e.g., alcoholics, former addicts, and other severe psychoneurotics, has been reported to result in dependence on or habituation to the drug. Where excessive dosage has continued for weeks or months, dosage should be reduced gradually rather than abruptly stopped since withdrawal of a "crutch" may precipitate withdrawal reaction of greater proportions than that for which the drug was originally prescribed. Abrupt discontinuance of doses in excess of the recommended dose has resulted in some cases in the occurrence of epileptiform seizures.

Special care should be taken to warn patients taking meprobamate that tolerance to alcohol may be lowered with resultant slowing of reaction time and impairment of judgement and coordination.

USAGE IN PREGNANCY AND LACTATION: An increased risk of congenital malformations associated with the use of minor tranquilizers (meprobamate, chloral-

azepoxide, and diazepam) during the first trimester of pregnancy has been suggested in several studies. Because use of these drugs is rarely a matter of urgency, their use during this period should almost always be avoided. The possibility that a woman of child-bearing potential may be pregnant at the time of institution of therapy should be considered. Patients should be advised that if they become pregnant during therapy or intend to become pregnant they should communicate with their physicians about the desirability of discontinuing the drug.

Meprobamate passes the placental barrier. It is present both in umbilical-cord blood and in neonatal plasma levels and in breast milk of lactating mothers at concentrations two to four times that of maternal plasma. When use of meprobamate is contemplated in breast-feeding patients, the drug's higher concentrations in breast milk as compared to maternal plasma levels should be considered.

Preparations containing aspirin should be kept out of the reach of children. Equagesic is not recommended for patients 12 years of age and under.

PRECAUTIONS: Should drowsiness, ataxia, or visual disturbance occur, the dose should be reduced. If symptoms continue, patients should not operate a motor vehicle or any dangerous machinery.

Suicidal attempts with meprobamate have resulted in coma, shock, vasomotor and respiratory collapse, and anuria. Very few suicidal attempts were fatal, although some patients ingested very large amounts of the drug (20 to 40 gm). These doses are much greater than recommended. The drug should be given cautiously and in small amounts, to patients who have suicidal tendencies. In cases where excessive doses have been taken, sleep ensues rapidly and blood pressure, pulse, and respiratory rates are reduced to basal levels. Hyperventilation has been reported occasionally. Any drug remaining in the stomach should be removed and symptomatic treatment given. Should respiration become very shallow and slow, CNS stimulants, e.g., caffeine, Metrazol, or am-

phetamine, may be cautiously administered. If severe hypotension develops, pressor amines should be used parenterally to restore blood pressure to normal levels.

ADVERSE REACTIONS: A small percentage of patients may experience nausea with or without vomiting and epigastric distress. Dizziness occurs rarely when meprobamate and ethoheptazine citrate with aspirin is administered in recommended dosage. The meprobamate may cause drowsiness but, as a rule, this disappears as therapy is continued. Should drowsiness persist and be associated with ataxia, this symptom can usually be controlled by decreasing the dose, but occasionally it may be desirable to administer central stimulants such as amphetamine or mephentermine sulfate concomitantly to control drowsiness.

A clearly related side effect to the administration of meprobamate is the rare occurrence of allergic or idiosyncratic reactions. This response develops, as a rule, in patients who have had only 1-4 doses of meprobamate and have not had a previous contact with the drug. Previous history of allergy may or may not be related to the incidence of reactions.

Mild reactions are characterized by an itchy urticarial or erythematous maculopapular rash which may be generalized or confined to the groin. Acute nonthrombocytopenic purpura with cutaneous petechiae, ecchymoses, peripheral edema, and fever have also been reported.

More severe cases, observed only very rarely, may also have other allergic responses including fever, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anaphylaxis, stomatitis and proctitis (1 case), and hyperthermia. Treatment should be symptomatic such as administration of epinephrine, antihistamine, and possibly hydrocortisone. Meprobamate should be stopped, and resumption of therapy should not be attempted.

Rare cases have been reported where patients receiving meprobamate suffered from aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis, and hemolytic anemia. In nearly every instance reported, other toxic agents known to have caused these conditions have been associated with meprobamate. A few cases of leukopenia during

continuous administration of meprobamate are reported, most of these returned to normal without discontinuation of the drug.

Impairment of accommodation and visual acuity has been reported rarely.

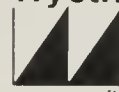
OVERDOSE: Two instances of accidental or intentional significant overdosage with ethoheptazine citrate combined with aspirin have been reported. These were accompanied by symptoms of CNS depression, including drowsiness and light-headedness, with uneventful recovery. However, on the basis of pharmacological data, it may be anticipated that CNS stimulation could occur. Other anticipated symptoms would include nausea and vomiting. Appropriate therapy of signs and symptoms as they appear is the only recommendation possible at this time. Overdosage with ethoheptazine combined with aspirin would probably produce the usual symptoms and signs of salicylate intoxication. Observation and treatment should include induced vomiting or gastric lavage, specific parenteral electrolyte therapy for ketoacidosis and dehydration, watching for evidence of hemorrhagic manifestations due to hypoprothrombinemia which it occurs, usually requires whole-blood transfusions.

DESCRIPTION: Each Equagesic tablet contains 150 mg meprobamate, 75 mg ethoheptazine citrate and 250 mg aspirin.

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*This drug has been evaluated as possibly effective for this indication.

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WYGESIC—Abbreviated Summary

INDICATION: For the relief of mild-to-moderate pain.

CONTRAINDICATION: Hypersensitivity to propoxyphene or to acetaminophen.

WARNINGS: CNS ADDITIVE EFFECTS AND OVERDOSAGE: Propoxyphene in combination with alcohol, tranquilizers, sedative-hypnotics, or other CNS depressants has an additive depressant effect. Patients taking this drug should be advised of the additive effect and warned not to exceed the dosage recommended. Toxic effects and fatalities have occurred following overdoses of propoxyphene alone or in combination with other CNS depressants. Most of these patients had histories of emotional disturbances or suicidal ideation or attempts, as well as misuse of tranquilizers, alcohol, or other CNS-active drugs. Caution should be exercised in prescribing large amounts of propoxyphene for such patients (see **Management of Overdose**).

DRUG DEPENDENCE: Propoxyphene can produce drug dependence characterized by psychic dependence and less frequently, physical dependence and tolerance. It will only partially suppress the withdrawal syndrome in individuals physically dependent on morphine or other narcotics. The abuse liability of propoxyphene is qualitatively similar to codeine's although quantitatively less, and propoxyphene should be prescribed with the same degree of caution appropriate to the use of codeine.

USAGE IN AMBULATORY PATIENTS: Propoxyphene may impair the mental and/or physical abilities required for potentially hazardous tasks, e.g. driving a car or operating machinery. Patients should be cautioned accordingly.

USAGE IN PREGNANCY: Safe use in pregnancy has not been established relative to possible adverse effects on fetal development. INSTANCES OF WITHDRAWAL SYMPTOMS IN THE NEONATE HAVE BEEN REPORTED FOLLOWING USAGE DURING PREGNANCY. Therefore, propoxyphene should not be used in pregnant women unless, in the

judgement of the physician, the potential benefits outweigh the possible hazards.

USAGE IN CHILDREN: Propoxyphene is not recommended for children because documented clinical experience has been insufficient to establish safety and a suitable dosage regimen in the pediatric group.

PRECAUTIONS: Confusion, anxiety, and tremors have been reported in a few patients receiving propoxyphene concomitantly with orphenadrine. The CNS depressant effect of propoxyphene may be additive with other CNS depressants, including alcohol.

ADVERSE REACTIONS: The most frequent adverse reactions are dizziness, sedation, nausea, and vomiting. These seem more prominent in ambulatory than in nonambulatory patients; some of these reactions may be alleviated if the patient lies down. Other adverse reactions include constipation, abdominal pain, skin rashes, light-headedness, headache, weakness, euphoria, dysphoria, and minor visual disturbances. The chronic ingestion of propoxyphene in doses over 800 mg per day has caused toxic psychoses and convulsions. Cases of liver dysfunction have been reported.

DRUG INTERACTIONS: Propoxyphene in combination with alcohol, tranquilizers, sedative-hypnotics, and other CNS depressants has an additive depressant effect. Patients taking this drug should be advised of the additive effect and warned not to exceed the dosage recommended (see **Warnings**). Confusion, anxiety, and tremors have been reported in a few patients receiving propoxyphene concomitantly with orphenadrine.

MANAGEMENT OF OVERDOSAGE: SYMPTOMS: The manifestations of serious overdose with propoxyphene are similar to those of narcotic overdose and include respiratory depression (a decrease in respiratory rate and/or tidal volume, Cheyne-Stokes respiration, cyanosis), extreme somnolence progressing to stupor or coma, pupillary constriction, and circulatory collapse. In addition to these characteristics, which are reversed by narcotic antago-

nists such as naloxone, there may be other effects. Overdoses of propoxyphene can cause delay of cardiac conduction as well as focal or generalized convulsions, a prominent feature in most cases of severe poisoning. Cardiac arrhythmias and pulmonary edema have occasionally been reported, and apnea, cardiac arrest, and death have occurred.

Symptoms of massive overdose with acetaminophen may include nausea, vomiting, anorexia, and abdominal pain, beginning shortly after ingestion and lasting for 12 to 24 hours. However, early recognition may be difficult since early symptoms may be mild and nonspecific. Evidence of liver damage is usually delayed. After the initial symptoms, the patient may feel less ill; however, laboratory determinations are likely to show a rapid rise in liver enzymes and bilirubin. In case of serious hepatotoxicity, jaundice, coagulation defects, hypoglycemia, encephalopathy, coma, and death may follow. Renal failure due to tubular necrosis, and myocardiopathy, have also been reported.

Ingestion of 10 grams or more of acetaminophen may produce hepatotoxicity. A 13-gram dose has reportedly been fatal.

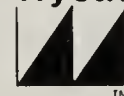
TREATMENT: Primary attention should be given to the reestablishment of adequate respiratory exchange through provision of a patent airway and institution of assisted or controlled ventilation. The narcotic antagonists, naloxone, nalorphine, and levallorphan, are specific antidotes against the respiratory depression produced by propoxyphene. An appropriate dose of one of these antagonists should be administered, preferably IV, simultaneously with efforts at respiratory resuscitation and the antagonist should be repeated as necessary until the patient's condition remains satisfactory. In addition to a narcotic antagonist, the patient may require careful titration with an anticonvulsant to control seizures. Analeptic drugs (e.g. caffeine or amphetamine) should not be used because of their tendency to precipitate convulsions.

Oxygen, IV fluids, vasopressors and other supportive measures should be used as indicated. Gastric lavage may be helpful. Activated charcoal can absorb a significant amount of ingested propoxyphene. Dialysis is of little value in poisoning by propoxyphene alone. Acetaminophen is rapidly absorbed, and efforts to remove the drug from the body should not be delayed. Copious gastric lavage and/or induction of emesis may be indicated. Activated charcoal is probably ineffective unless administered almost immediately after acetaminophen ingestion. Neither forced diuresis nor hemodialysis appears to be effective in removing acetaminophen. Since acetaminophen in overdose may have an antidiuretic effect and may produce renal damage, administration of fluids should be carefully monitored to avoid overload. It has been reported that mercaptamine (cysteine) or other thiol compounds may protect against liver damage if given soon after overdose (8-10 hours). N-acetylcysteine is under investigation as a less toxic alternative to mercaptamine, which may cause anorexia, nausea, vomiting, and drowsiness. Appropriate literature should be consulted for further information. (JAMA 237:2406-2407, 1977).

Clinical and laboratory evidence of hepatotoxicity may be delayed up to one week. Acetaminophen plasma levels and half-life may be useful in assessing the likelihood of hepatotoxicity. Serial hepatic enzyme determinations are also recommended.

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Increases in medical students' indebtedness to have profound impact on medical education

By John Richards, chief, MSMS Bureau of Economics

Presently there are 2,420 students attending medical school in Michigan. Seventy-three percent, or 1,767, will finish their education in debt.

This is an increase of 29 percent since 1968, when 44 percent of the students were in debt at the end of their education.

This situation will have a substantial impact on the number, type and career decisions of students entering medical school.

A recent report to the AMA House of Delegates states, "This is bound (student indebtedness) to impede the application and admission of talented students with limited means. The central premise of all actions which attempt to secure financial assistance for medical students should be that the attainment of a medical degree should be reserved for the most able, the brightest and the most dedicated . . . not for the rich, the luckiest and the most fortunate."

Debts rising

The fact remains that students entering medical school in Michigan are facing the problem of financing between \$11,000 and \$15,000 per year in tuition and living expenses. Only a small number of students manage to accomplish this without incurring debts which must be repaid when the physician begins practice.

Fifty-five percent of the medical students surveyed in 1977-78 anticipated debts of more than \$15,000 total for their education. In fact, the size of the debt has increased dramatically in the past 10 years, rising from a national average in 1968 of \$3,050 to \$10,450 in 1979. And this increase is continuing.

Compounding the problem are the present economic conditions and a possible major shift in national policy regarding the financing of medical education.

Loans from private sources are becoming increasingly more difficult to obtain. This is a general trend in the economy as efforts to control inflation have focused on limiting investment capital.

Even when these loans are available, present interest rates require the commitment of a substantial amount of resources to repay them after a physician begins practice. This situation not only affects the type of individual applying for medical school, but in the long run, also may aggravate health care cost increases, as young physicians will be required to generate ever increasing amounts of revenue to repay the debts.

National policy increasingly is directed to treating medical education as a capital investment rather than a social responsibility. In the past, government felt the need to train sufficient numbers of physicians was a public responsibility deserving subsidies from tax dollars. This attitude recently has begun to change, most likely as a result of the present projection of an over-supply of physicians by 1990.

Support decreasing

Legislation authorizing capitation grants to medical schools expires in 1981. Renewal of this money is presently being opposed by the President. If this legislation is not renewed, there will be a substantial impact on the financial structure of medical schools.

Additional federal scholarship programs have been greatly reduced

with the emphasis shifting from grants to loans. The majority of the loans available from the federal government are National Health Service Corps or Armed Forces Health Professional Scholarships, requiring substantial services obligation after completion of the educational program. (See Table 1.)

Presently the Michigan legislature is considering HB 4085, a bill to establish a Health Service Corps. This bill would require an individual to serve a minimum of two years in a designated shortage area or repay three times the amount of the loan.

At the present time the bill has passed the House Committee on Public Health and is now in the House Appropriations Committee. This means the probability of action on the bill in this session of the legislature is unlikely.

Conclusion

It is apparent future medical students will be required to finance their education with increasing amounts of loans. Compounding the problem are a current shortage of capital available to loan to students and the substantial interest rates individuals must pay for these loans.

National policy is changing in the direction of placing greater economic burdens on medical students and away from scholarships and grants. This serves to direct increasing numbers of students toward low cost government loan programs requiring the physician to serve in designated areas or in the Armed Services to repay these loans.

A policy of not subsidizing medical education will have a substantial impact on the type of individual applying to medical school. If this trend

MED SCHOOLS/continued
 continues, only the privileged will have access to a medical education. The gains made in the past years in minority enrollments will be eliminated as the poor or average income individuals will find it too costly to attend medical school.

Those individuals completing

their education will be facing substantial debts. Decisions regarding specialty and location of practice will be dictated by the need to generate income to repay this indebtedness.

At the present time it seems this trend will continue; that is, unless the public and the government make

a commitment to provide the financial assistance necessary to insure medical education remains within the reach of all individuals displaying the talents and dedication necessary to complete their education and serve in the communities where they are most needed.

Table 1						
1977-1978*				1978-1979†		
	Amount, \$	No.	Average Amount, \$	Amount, \$	No.	Average Amount, \$
Not administered by schools						
Scholarships						
Armed Forces Health Professions Scholarships	24,756,955	2,839	8,720	29,607,671	3,013	9,826
National Health Service Corps	25,193,910	2,391	10,536	37,932,098	3,674	10,324
Physician shortage area‡	873,384	200	4,366	0	0	0
National medical fellowships	1,072,760	1,211	885	568,950	730	779
Other (with service commitment)	3,329,660	769	4,329	4,427,598	1,362	3,250
Subtotal	55,226,669	7,410	7,452	72,536,317	8,779	8,262
Loans						
AMA-ERF§	5,577,312	3,883	1,436	2,838,922	1,640	1,731
Guaranteed loans	75,203,687	25,487	2,950	99,647,902	28,227	3,799
Other loans	5,634,555	4,738	1,189	7,094,988	5,182	1,369
Subtotal	86,415,554	34,108	2,533	109,581,812	33,049	3,315
College work-study	775,324	867	894	775,495	980	791
Total	142,417,547	42,385	3,360	182,894,624	42,808	4,272
Administered by schools						
Scholarships						
Exceptional financial needs	0	0	0	2,545,283	283	9,677
Health Professions Scholarships‡	440,908	252	1,794	0	0	0
School funds	18,333,749	11,751	1,560	20,043,685	10,951	1,830
Other scholarships	5,451,199	4,642	1,174	9,503,681	5,734	1,657
Subtotal	24,225,856	16,645	1,455	32,092,649	16,948	1,893
Loans						
Health professions loans	18,965,466	10,926	1,735	19,756,213	9,808	2,014
United Student Aid Loans¶	0	0	0	3,188,692	1,605	1,986
Guaranteed loans	3,753,098	1,870	2,007	6,100,239	1,531	3,984
National Direct Student Loans	9,300,536	5,527	1,772	12,803,924	6,798	1,883
School funds	7,726,647	6,585	1,173	7,287,823	5,669	1,285
Subtotal	39,745,747	24,628	1,613	49,136,891	25,411	1,933
Total	63,971,603	41,273	1,549	78,040,848	40,754	1,914
Grand Total	206,389,150	83,658	2,467	264,124,164	85,167	3,101
* One hundred sixteen schools reported. † One hundred nineteen schools reported. ‡ 1977-1978 was last year of program funding. § 1977-78 American Medical Association — Education and Research Foundation data corrected from last year's table. Funded for the first time in 1978-79. ¶ Robert Wood Johnson/United Student Aid Funds are included in other loans for 1977-1978.						

Table 2	
Name of School	Tuition
Hahnemann	\$10,000
Dartmouth	8,015
Northwestern	7,550
Michigan, University of	2,300
Maryland, University of	2,250
Ohio State University	2,200
Vermont, University of	2,200
Cincinnati	2,151
Michigan State University	2,100
Wayne State University	2,080
Texas A & M	267
Texas Tech	267
Marshall	180

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The 1980 MSMS House of Delegates enthusiastically challenged MSMS and the medical community to make an aggressive effort to prepare and inform physician leaders. Thus, this program will concentrate

on those professional, socioeconomic, political and administrative trends, ideas and problems that are clearly and, in some cases, ominously, visible on the professional horizon for every practicing physician today.

This promises to be a day well spent in professional growth and fellowship!

The program

9:00 REGISTRATION

9:30 CALL TO ORDER — John R. Ylvisaker, MD, MSMS President

9:45 "AMERICA AT THE POLLS" — Richard Scammon, Director, Elections Research Center, Washington, DC

10:45 "POLITICAL ACTION — MDPAC" — Thomas C. Payne, MD, Chairman, Michigan Doctors Political Action Committee

11:00 "FEDERAL TRADE COMMISSION DEVELOPMENTS" — Louis R. Zako, MD, Chairman, Michigan State Medical Society Council

11:15 "ON THE STAND . . ." — A. Stewart Kerr, MSMS Legal Counsel, Kerr, Russell and Weber, Detroit

11:30 "REVIEW, PREVIEW AND PROGNOSTICATIONS FROM THE UNITED STATES SENATE" — Honorable Carl Levin, United States Senator

12:15 LUNCH — Luncheon Speaker, Robert T. Kelly, MD, Minnesota, AMA Board of Trustees

1:30 "INTERNAL OPERATIONS AT MSMS HEADQUARTERS" — Thomas Berglund, MD, Vice-Chairman, MSMS Council

2:00 "MEDICAID DURING THE MICHIGAN RECESSION" — David Siegel, MD, Chairman, Medicaid Liaison Committee

2:20 "BLUE CROSS/BLUE SHIELD REFORM" — W. E. Maldonado, MD, Chairman, Committee on State Legislation and Regulations

2:40 "GROWTH IN HMO-IPA PREPAYMENT PLANS IN MICHIGAN" — Jay Harness, MD, Chairman, Advisors to the Bureau of Economics

3:00 "PSRO-OUR UNITED EFFORT" — Daniel J. Fall, MD, President, Michigan Statewide Professional Standards Review Council Inc.

3:15 "PROFESSIONAL LIABILITY INSURANCE IN MICHIGAN" — Robert M. Leitch, MD, President, Michigan Physicians Mutual Liability Company

3:30 "THE NATURE OF LEADERSHIP IN MEDICINE: There's a Lot We Physicians Can Do" — Ed Annis, MD, Former AMA President, Presently — Consultant, Mutual Association for Professional Services

Please return to:

**1980 Public Affairs Leadership Conference
Michigan State Medical Society
P.O. Box 950
East Lansing, Michigan 48823**

Name _____

City _____

Name _____

City _____

For telephone reservations:
Please contact Bill Madigan
or Kevin Kelly
at MSMS Headquarters —
517/337-1351.

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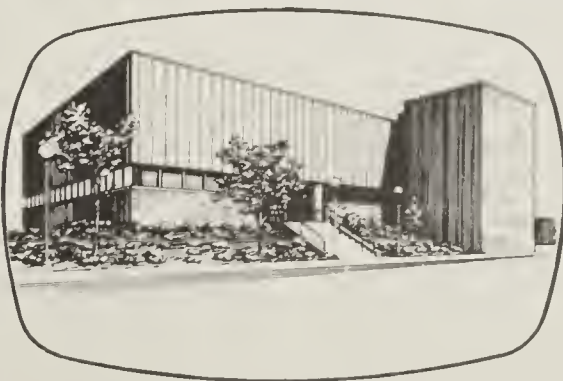
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MEETINGS

MSMS, AMA, MSMS/A and medical assistants

Sept. 27-29 — AMA meeting, "Drugs in Medical Practice," Crown Center Hotel, Kansas City, contact: Department of Scientific Assembly, AMA, 535 N. Dearborn St., Chicago, 60610.

Oct. 12-17 — American Association of Medical Assistants, Inc. National Convention, Kansas City, contact: Caroline Rich, MSMS headquarters.

Oct. 15 — AMA meeting, "Newer Clinical Approaches to Sexually Transmissible Diseases," contact: Department of Environmental, Public and Occupational Health, AMA, 535 N. Dearborn St., Chicago, 60610.

Oct. 17-18 — MSMS/Intrav Western Mediterranean Air/Sea Cruise, contact: Marcelyn Ireland, MSMS headquarters. 517/337-1351.

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Oct. 22 — MSMS Council, MSMS headquarters, contact: Warren Tryloff, MSMS headquarters.

Oct. 24-25 — AMA Fourth National Conference on Medical Care and Health Services in Correctional Institutions, Chicago, contact: AMA Correctional Programs, 535 N. Dearborn St., Chicago, 60610.

Oct. 29-Nov. 1 — AMA Fourth National Conference on the Impaired Physician, Baltimore, MD, contact: Department of Mental Health, AMA, 535 N. Dearborn St., Chicago, 60610.

Oct. 30 — First Annual MSMS Public Affairs Leadership Conference, Long's Convention Center, Lansing, contact: William Madigan or Kevin Kelly, MSMS headquarters. 517/337-1351.

Nov. 8-9 — Fall Leadership Training Seminar, State of Michigan Branch, American Association of Medical Assistants, site to be determined, contact: Caroline Rich, MSMS headquarters.

Nov. 9 — Board Meeting, State of Michigan Branch, American Association of Medical Assistants, site to be determined, contact: Caroline Rich, MSMS headquarters.

Nov. 18-20 — MSMS Annual Scientific Meeting, Hyatt Regency Dearborn, contact: Sherry Fent, MSMS headquarters.

Dec. 3 — MSMS Council, MSMS headquarters, contact: Warren Tryloff, MSMS headquarters.

Dec. 7-10 — AMA House of Delegates, San Francisco, contact: AMA, 535 N. Dearborn St., Chicago, 60610.

Jan. 4-7, 1981 — 7th AMA State Health Legislation Meeting, Sonesta Beach Hotel and Tennis Club, Key Biscayne, contact: Department of State Legislation, AMA, 535 N. Dearborn St., Chicago, 60610.

Other meetings

Sept. 25-27 — 1980 Walter P. Work Society, Stanford Court Hotel, San Francisco, contact: Nels R. Olson, MD, Box 61, University Hospital, Ann Arbor, 48109.

Oct. 12-14 — Michigan Alcohol and Addiction Association Fall Conference, Hilton Shanty Creek Resort, Bellaire, contact: Michigan Alcohol and Addiction Association, 23450

Middlebelt, Farmington Hills, 48024. 313/474-1291.

Oct. 14 — "Law and the Emergency Department," sponsored by the Michigan Mid-South Emergency Medical Services and MSU's Lifelong Education Programs, Michigan State University, contact: MSU Office of Conferences and Institutes, 517/355-4577.

Oct. 19-23 — 108th Annual Meeting of the American Public Health Association, Detroit, contact: American Public Health Association, 1015 15th St., N.W., Washington, D.C. 20005.

Oct. 20-22 — Michigan Rehabilitation Association Conference, "A New Focus: Implications for Service," Marriott Inn, Grand Rapids, contact: Florence Johnson, 1020 Hastings St., Traverse City, 49684. 616/947-6460.

Oct. 25-30 — Annual Meeting, American Academy of Pediatrics, Detroit, contact: Robert S. Holm, MD, Southwestern Michigan Area Health Education Center, 252 E. Lovell St., Kalamazoo, 49007. 616/383-6360.

Nov. 5 — Board Meeting, Michigan Chapter, American College of Emergency Physicians, MSMS headquarters, contact: Michigan Chapter, ACEP, P.O. Box 1611, East Lansing, 48823. 517/332-6500.

Nov. 6 — Michigan Family Practice Research Day IV, sponsored by Department of Family Practice, Michigan State University and Michigan Academy of Family Physicians, at MSU University Club, contact: Doug McKeag, MD, Department of Family Practice, B-100 Clinical Center, Michigan State University, East Lansing, 48824. 517/353-0770.

Nov. 19 — Michigan Society of General Surgeons Annual Membership Meeting, Hyatt Regency Dearborn, contact: Caroline Rich, MSMS headquarters. 517/337-1351.

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1981 Michigan Conference on Maternal and Perinatal Health

March 25

- Management of Premature Labor
- Diagnosis and Management of Intrauterine Growth Retardation: The Mother/The Newborn
- The Resuscitation Team: How to Build the Best
- When and When Not to Resuscitate
- Resuscitation: Its Ethical Considerations
- Resuscitation: What are the Legal Implications

March 26

- How Bad is Bad: What are the Degrees of Abnormality?
- Why Did It Happen to Our Baby?
- After the Neonatal ICU:
To the Nursery/Into the Community
- Burnout: How Do You Avoid It?

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PRECAUTIONS: Thrombocytopenic purpura may follow the administration of quinine in highly sensitive patients. Recovery will follow withdrawal of the medication. Cinchona alkaloids, including quinine, have the potential to depress the hepatic enzyme system that synthesizes the vitamin K-dependent factors. The resulting hypoprothrombinemic effect may enhance the action of warfarin and other oral anticoagulants.

ADVERSE REACTIONS: Aminophylline may produce intestinal cramps in some instances, and quinine may produce symptoms of cinchonism, such as tinnitus, dizziness, and gastrointestinal disturbance. If ringing in the ears, deafness, skin rash, or visual disturbances occur, the drug should be discontinued.

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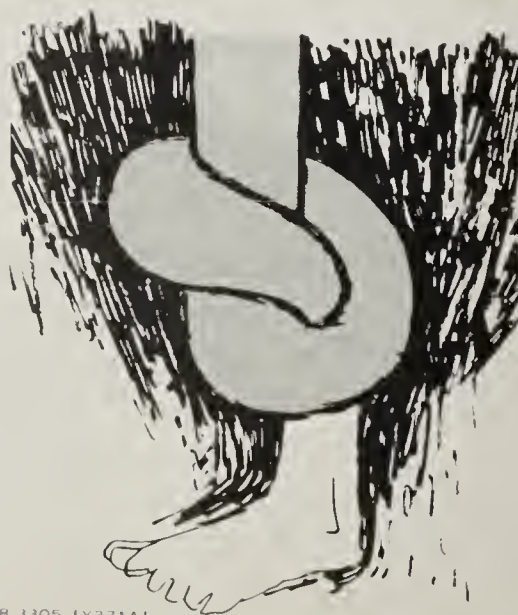
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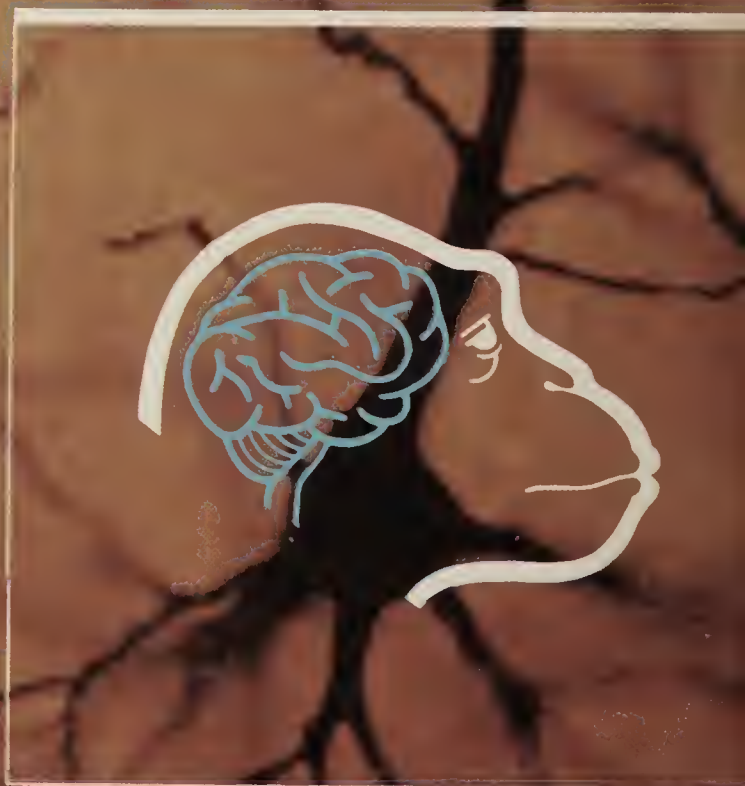
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Indications: Relief of anxiety and tension occurring alone or accompanying various disease states. Efficacy beyond four months not established by systematic clinical studies. Periodic reassessment of therapy recommended

Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Warn patients that mental and/or physical abilities required for tasks such as driving or operating machinery may be impaired, as may be mental alertness in children, and that concomitant use with alcohol or CNS depressants may have an additive effect. Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported.

Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

Usual Daily Dosage: Individualize for maximum beneficial effects. *Oral-Adults:* Mild and moderate anxiety and tension, 5 or 10 mg *t.i.d.* or *q.i.d.*; severe states, 20 or 25 mg *t.i.d.* or *q.i.d.* *Geriatric patients:* 5 mg *b.i.d.* to *q.i.d.* (See Precautions.)

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CATEGORY I COURSES

Michigan Medicine each month carries a list of opportunities in Michigan for doctors of medicine to obtain Category I credit toward meeting the requirements of Michigan law. Sponsors of Category I programs and courses in Michigan are invited to submit information for the monthly calendar.

Each listing below, of programs that carry at least 3 hours of Category I credit, indicates a contact person, so the physician can obtain details. Physicians with questions about accredited programs may phone MSMS Headquarters, 517/337-1351.

Date: Sept. 11-14, **Upper Peninsula Medical Society Meeting.** **Location:** Mackinac Island. **Sponsor:** Upper Peninsula Medical Society. **For:** All interested physicians. **Cost:** \$125. **Contact:** Frederick E. Ludwig, MD, 906/265-5101. **Approved for:** 17 hours of Category I Credit.

Date: Sept. 13, **The Practical Application of Electron Microscopy to Surgical Pathology.** **Location:** Munson Medical Center, Traverse City. **Sponsor:** Michigan Society of Pathologists. **For:** Pathologists. **Contact:** T. A. Reyman, MD, Department of Pathology, Mt. Carmel Mercy Hospital, Detroit, 48235. **Approved for:** 3 hours of Category I Credit.

Date: Sept. 15-19, **Seventh Annual Family Practice Review.** **Location:** Gordon H. Scott Hall, Wayne State University, Detroit. **Sponsor:** Wayne State University School of Medicine and Michigan Academy of Family Physicians. **For:** All interested physicians. **Cost:** \$200. **Contact:** Wayne State University School of Medicine, Division of Continuing Medical Education, 1206 Scott Hall, Detroit, MI 48202, 313/577-1180. **Approved for:** 42½ hours of Category I Credit.

Date: Sept. 18, **Endocrinology Update.** **Location:** Medical Arts Auditorium, McPherson Community Health Center, Howell. **Sponsor:** McPherson Community Health Center. **For:** All interested physicians. **Contact:** E. S. Woodworth, MD, Chairman, 517/546-1410. **Approved for:** 4 hours of Category I Credit.

Date: Sept. 17, **A Day On Cardiac Pacing.** **Location:** Michigan Inn, Southfield. **Sponsor:** Henry Ford Hospital. **For:** All interested physicians. **Cost:** \$40. **Contact:** Medical Education, Henry Ford Hospital, 2799 W. Grand Blvd., Detroit, 48202 313/876-1464. **Approved for:** 5 hours of Category I Credit.

Date: Sept. 18, **Accreditation Seminar for Hospital Laboratory Services.** **Location:** Detroit. **Sponsor:** Joint Commission on Accreditation of Hospitals. **Co-Sponsor:** Michigan Hospital Association. **For:** Laboratory directors, pathologists, and administrative and other personnel involved with laboratory services. **Contact:** Maryanne Butt, Michigan Hospital Association, 2213 E. Grand River, Lansing, 48912. 517/484-7441. **Approved for:** 7½ hours of Category I Credit.

Date: Sept. 22-23, **Hospital — Home Interface: Rehabilitation in the 80's.** **Location:** Towsley Center, Ann Arbor. **Sponsor:** U-M Continuing Medical Education Department. **For:** All interested physicians. **Cost:** \$120. **Contact:** Towsley Center for CME, 313/764-2287. **Approved for:** 14½ hours of Category I Credit.

Date: Sept. 24, **Renal Problems for the Practicing Physician.** **Location:** Kalamazoo Center, Kalamazoo. **Sponsor:** Michigan Nephrology Center. **Co-Sponsor:** Southwestern Michigan Area Health Education Center. **For:** All primary care physicians. **Cost:** \$40. **Contact:** Charles L. Zeller, Jr., MD, Continuing Medical Education, 252 East Lovell, Room 364, Kalamazoo, 49007. **Approved for:** 7 hours of Category I Credit.

Date: Sept. 24-25, **1980 Western Michigan Trauma Symposium.** **Location:** East Auditorium, Butterworth Hospital, Grand Rapids.

Sponsor: Greater Grand Rapids Area, American Association of Critical Care Nurses. **For:** All interested medical and paramedical personnel. **Cost:** \$15 per day. **Contact:** Beth DeVriendt, Butterworth Hospital, 100 Michigan St., NE, Grand Rapids, 49503 (616/774-1405). **Approved for:** 15 hours of Category I Credit.

Date: Sept. 25-28, **Nitrosoureas: Current Status and New Developments.** **Location:** Hyatt Regency Dearborn. **Sponsor:** Wayne State University School of Medicine Department of Oncology, Harper-Grace Hospitals and the Comprehensive Cancer Center of Metropolitan Detroit and Bristol Laboratories. **For:** All interested physicians. **Contact:** David Moss, Symposium Coordinator, Bristol Laboratories, P.O. Box 657, Syracuse, NY 13201. **Approved for:** 12 hours of Category I Credit.

Date: Sept. 25-27, **Electrophysiology of Cardiac Arrhythmias and Conduction Defects.** **Location:** Detroit Plaza Hotel. **Sponsor:** Michigan Heart Association and Council on Clinical Cardiology of the American Heart Association. **For:** All interested physicians. **Contact:** Eleanor D. Peterson, RN, Michigan Heart Association, P.O. Box LV 160, Southfield, 48076. 313/557-9500. **Approved for:** 16½ hours of Category I Credit.

Date: Sept. 27, **What's New in the Chest.** **Location:** Education and Research Center, Henry Ford Hospital. **Sponsor:** Henry Ford Hospital. **For:** All interested physicians. **Contact:** Medical Education, Henry Ford Hospital, 2799 W. Grand Blvd., Detroit, 48202 313/876-1464. **Approved for:** 7 hours of Category I Credit.

Date: Oct. 2, **Perinatal Association of Michigan Conference on Risk Assessment, Screening and Management.** **Location:** Long's Convention Center, Lansing. **Sponsor:** Perinatal Association of Michigan. **Co-Sponsor:** E. W. Sparrow Hospital. **For:** All interested physicians. **Cost:** PAM Members: \$35, Non-PAM Members: \$50. **Contact:** Max Alderson, Michigan Dept. of Public Health, 3500 N. Logan St., P.O. Box 30035, Lansing, 48909. **Approved for:** 6 hours of Category I Credit.

Date: Oct. 2-5, **Michigan Chapter, American College of Physicians Regional Meeting.** **Location:** Sugar Loaf, Cedar. **Sponsor:** Michigan Chapter, American College of Physicians. **For:** Internists and family physicians. **Contact:** Boy Frame, MD, Henry Ford Hospital, 2799 W. Grand Blvd., Detroit, 48202. 313/876-2373. **Approved for:** 20 hours of Category I Credit.

Date: Oct. 3-5, **Diagnostic Ultrasound.** **Location:** Towsley Center, Ann Arbor. **Sponsor:** U-M Office of Continuing Medical Education. **For:** All interested physicians. **Cost:** \$175. **Contact:** Towsley Center for CME, 313/764-2287. **Approved for:** 16 hours of Category I Credit.

Date: Oct. 4-5, **Northern Michigan Hospitals 8th Annual Medical Meeting.** **Location:** Holiday Inn, Traverse City. **Sponsor:** Northern Michigan Hospitals, Inc. **For:** All interested physicians. **Contact:** G.A. Uhlich, MD, 1718 E. Mitchell Rd., Petoskey, 49770. **Approved for:** 12 hours of Category I Credit.

Date: Oct. 4-5, **Anesthesia, Obstetrics and the Newborn.** **Location:** Grand Traverse Hilton, Traverse City. **Sponsor:** Wayne State University School of Medicine and Michigan Society of Anesthesiologists. **For:** All interested physicians. **Cost:** \$75. **Contact:** Wayne State University School of Medicine, Division of CME, 9B-32 Health Care Institute, Detroit, 48201, (313) 577-1180. **Approved for:** 7 hours of Category I Credit.

Date: Oct. 4-5, **8th Annual Burns Clinic Medical Meeting.** **Location:** Holiday Inn, Petoskey. **Sponsor:** Burns Clinic Medical Center. **For:** All interested physicians. **Cost:** \$120. **Contact:** J. R. Postle, MD, Burns Clinic Medical Center, P.C., Petoskey, 49770, 616/347-7000, ext. 422. **Approved for:** 12 hours of Category I Credit. Also approved for 12 prescribed credit hours by the AAFP.

Date: Oct. 6-8, **Diabetes Mellitus Symposium.** **Location:** Towsley Center, Ann Arbor. **Sponsor:** U-M Office of Continuing Medical Education. **For:** All interested physicians. **Cost:** \$200. **Contact:** Towsley Center for CME, 313/764-2287. **Approved for:** 20 hours of Category I Credit.

Date: Oct. 8, **Selected Topics in Practical Cardiology.** **Location:** Education & Research Center, Henry Ford Hospital. **Sponsor:** Henry Ford Hospital. **For:** All interested physicians. **Contact:** Medical Education, Henry Ford Hospital, 2799 W. Grand Blvd., Detroit, 48202 313/876-1464. **Approved for:** 7 hours of Category I Credit.

Date: Oct. 9, **3rd Annual Doctor Jacob J. Miller Psychiatric Seminar.** **Location:** Mercywood Neuropsychiatric Hospital, Ann Arbor. **Sponsor:** Mercywood Neuropsychiatric Hospital. **For:** Psychiatrists. **Cost:** \$20 practicing professionals, \$10 non-practicing professionals. **Contact:** Mrs. Susan Berg, Mercywood Neuropsychiatric Hospital, P.O. Box 1127, Ann Arbor, 48106. 313/663-8571. **Approved for:** 6 hours of Category I Credit.

Date: Oct. 10-11, **Michigan Fall Radiological Conference.** **Location:** William Beaumont Hospital, Royal Oak. **Sponsor:** William Beaumont Hospital. **For:** Radiologists. **Contact:** J. Farah, MD, Dept. of Radiology, William Beaumont Hospital, Royal Oak, 48072. **Approved for:** 14 hours of Category I Credit.

Date: Oct. 15, **Pediatrics Infections.** **Location:** Hurley Medical Center, Merliss Brown Auditorium. **Sponsor:** Hurley Medical Center. **For:** All interested physicians. **Contact:** Richard D. Glick, Hurley Medical Center, Sixth Ave. and Begole, Flint, 48502 313/766-0142. **Approved for:** 6 hours Category I Credit.

Date: Oct. 15, **Heart Day II.** **Location:** Saint John Hospital, Detroit. **Sponsor:** Saint John Hospital. **For:** All interested physicians. **Cost:** \$100. **Contact:** Ms. Linda Radu, Office of CME, Saint John Hospital, 22102 Moross Rd., Detroit, 48236. 313/343-4000. **Approved for:** 8 hours of Category I Credit.

Date: Oct. 16-18, **Implant Surgery for Joints and Tendons in the Hand.** **Location:** Blodgett Memorial Medical Center. **Sponsor:** American Society for Surgery of the Hand. **For:** All interested physicians. **Contact:** Alfred B. Swanson, MD, 290 Blodgett Professional Building, 1900 Wealthy Street, S.E., Grand Rapids, 49506. **Approved for:** 18½ hours of Category I Credit.

Date: Oct. 18, **You Could Go to Court: Professional Liability — Medical and Legal Issues.** **Location:** Michigan Inn, Southfield. **Sponsor:** U-M Continuing Medical Education Department. **For:** All interested physicians. **Cost:** \$100. **Contact:** Towsley Center, 313/764-2287. **Approved for:** 7½ hours of Category I Credit.

Date: Oct. 23, **Pulmonary Emergencies.** **Location:** Education and Research Center, Henry

CATEGORY I/continued

Ford Hospital. **Sponsor:** Henry Ford Hospital. **For:** All interested physicians. **Contact:** Medical Education, Henry Ford Hospital, 2799 W. Grand Blvd., Detroit 48202 313/876-1464. **Approved for:** 7 hours of Category I Credit.

Date: Nov. 7-8, **Leukemias and Non-Hodgkin's Lymphomas: Clinico-Pathological Update.** **Location:** Hilton Inn, Lansing. **Sponsor:** Department of Laboratories, Edward W. Sparrow Hospital. **For:** All interested physicians. **Contact:** Janice Proudfoot, Education Coordinator, Edward W. Sparrow Hospital, 1215 E. Michigan Ave., P.O. Box 30480, Lansing, 48909. 517/487-2530. **Approved for:** 5 hours of Category I Credit.

Date: Nov. 8, **Symposium on Empathy and Countertransference.** **Location:** Hyatt Regency Dearborn. **Sponsor:** Michigan Psychoanalytic Society. **For:** Psychiatrists. **Contact:** The Michigan Psychoanalytical Society, 16310 West Twelve Mile Rd., Suite 204, Southfield, 48076. **Approved for:** 6 hours of Category I Credit.

Date: Nov. 13-14, **Seminar on Quality Assurance.** **Location:** Detroit. **Sponsor:** Joint Commission on Accreditation of Hospitals. **Co-Sponsor:** Michigan Hospital Association. **For:** Hospital management, medical and nursing staffs. **Contact:** Maryanne Butt, Michigan Hospital Association, 2213 E. Grand River, Lansing, 48912, 517/484-7441. **Approved for:** 11 hours of Category I Credit.

Date: Nov. 17-18, **Treatment of Injuries of the Hand: Primary and Definitive Care.** **Location:** Detroit Plaza Hotel. **Sponsor:** Wayne State University School of Medicine, Department of Surgery and American Society for Surgery of the Hand. **For:** All interested physicians. **Cost:**

\$250. **Contact:** Gerald F. Prieur, Jr., MPA, Wayne State University School of Medicine, Continuing Medical Education, 9B-32 Health Care Institute, Detroit, 48202, 313/577-1180. **Approved for:** 19 hours of Category I Credit.

Date: Nov. 18-20, **MSMS Annual Scientific Meeting.** **Location:** Hyatt Regency Dearborn. **Sponsor:** Michigan State Medical Society. **For:** All interested physicians. **Contact:** Sherry Fent, MSMS, 517/337-1351. **Approved for:** 18 hours of Category I Credit.

Date: Dec. 3, **Perspectives In Surgery.** **Location:** Saint John Hospital, Detroit. **Sponsor:** Saint John Hospital. **For:** All interested physicians. **Cost:** \$100. **Contact:** Ms. Linda Radu, Office of CME, Saint John Hospital, 22101 Moross Rd., Detroit, 48236. 313/343-4000. **Approved for:** 8 hours of Category I Credit.

Date: Dec. 6, 1980, **Practical Management of Common Neurosurgical Problems.** **Location:** Borgess Medical Center, Kalamazoo. **Sponsor:** Neurosurgery of Kalamazoo, P.C. and Borgess Medical Center. **Co-Sponsor:** Southwestern Michigan Area Health Education Center. **For:** All interested physicians. **Cost:** \$25. **Contact:** Charles L. Zeller, Jr., MD, SMAHEC, 252 E. Lovell, Kalamazoo, 49007. **Approved for:** 6 hours of Category I Credit.

Date: Dec. 13, **General Pathologic Problems Encountered in the Practice of Forensic Pathology.** **Location:** Towsley Center, Ann Arbor. **Sponsor:** Michigan Society of Pathologists. **For:** Pathologists. **Contact:** T. A. Reyman, MD, Department of Pathology, Mt. Carmel Mercy Hospital, Detroit, 48235. **Approved for:** 3 hours of Category I Credit.

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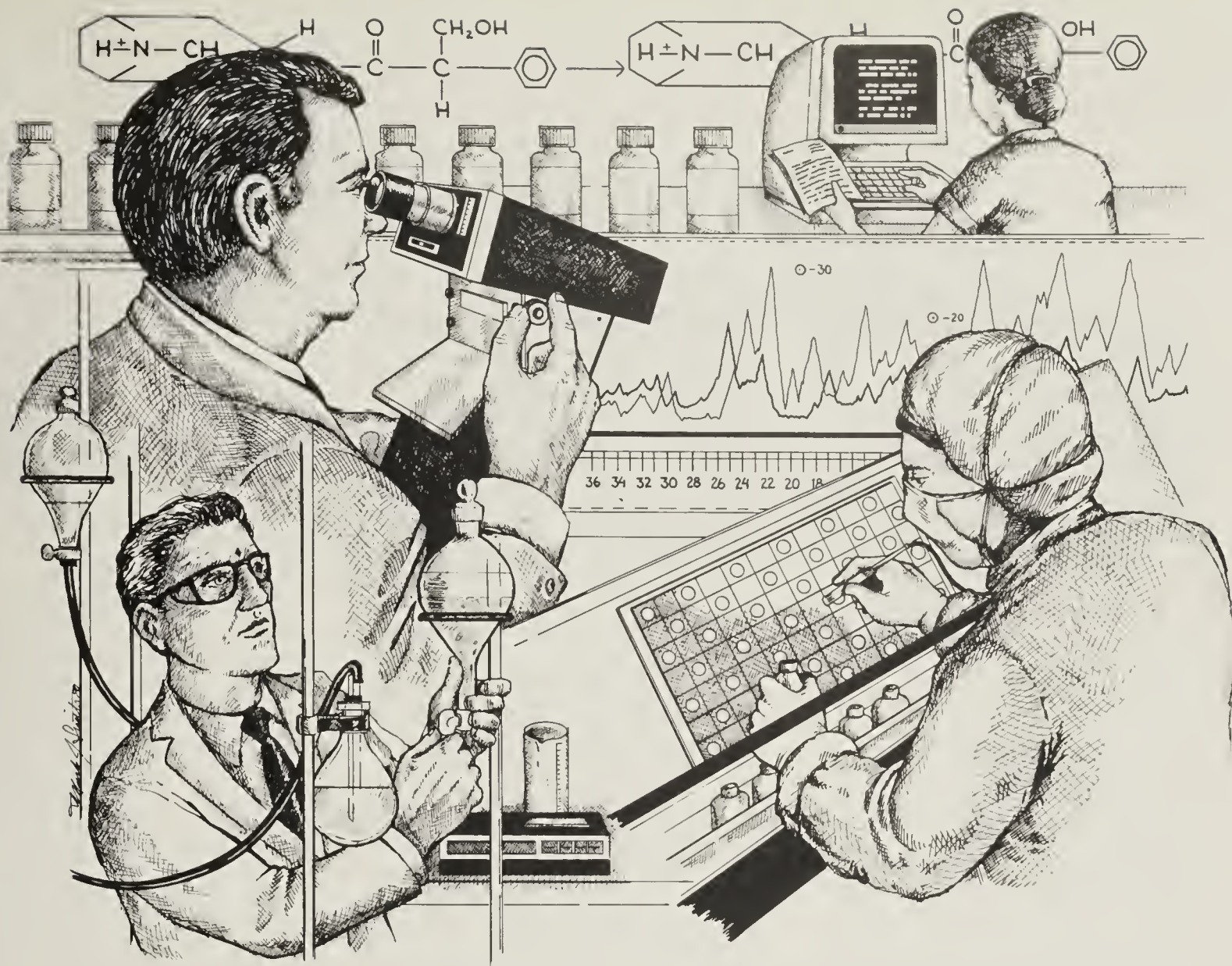
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Newly elected chairman of the FLEX Board of the Federation of State Medical Boards of the United States is **C. Allen Payne, MD**, Grand Rapids. . . . New officers of the Michigan Occupational Medical Association are: **Denis F. Cash, MD**, president, Bloomfield Hills; **Monroe S. Lechner, MD**, vice-president, Grosse Pointe, and **Lucius C. Tripp, MD**, president-elect, Birmingham. . . . **Henry S. Kaplan, MD**, Stanford University, received the Michigan Cancer Foundation's Prentis Medal for Outstanding Contributions to Cancer Research. . . . **Michael J. Brennan, MD**, Detroit, has assumed the duties of president and director for the Comprehensive Cancer Center of Metropolitan Detroit. The center was recognized as the 20th Comprehensive Cancer Center by the National Cancer Institute in 1978. . . . **Melvin Bornstein, MD**, Birmingham, was installed June 10 as president of the Michigan Psychoanalytic Society. **Ronald M. Benson, MD**, Ann Arbor, was chosen president-elect. Both will serve a two year term. . . . New senior vice-president for medical and educational affairs at the Detroit Medical Center is **Robert E. Mack, MD**, Detroit. The position was created to assist in the continuing development of the Detroit Medical Center's patient care, professional education and clinical research functions. . . . **William R. Schonbein** has assumed duties as vice-president for health services and facilities at Michigan State University. The new vice-president will be responsible for coordination and management of all university health care programs and the operation of all on-campus clinical activities of

campus-based faculty members. . . . **John M. Hartzell, MD**, Grosse Pointe, is new president of the Southeast Michigan Surgical Society. . . . Recently elected officers of the Michigan Radiological Society are: **Robert N. Songe, MD**, president, Dearborn; **Charles Krecke, MD**, president-elect, Grand Rapids, and **Forrest J. Arnoldi, MD**, secretary-treasurer, Detroit. . . . **John G. Weg, MD**, U-M professor of internal medicine, was re-elected chairman of the Board of Governors of the American College of Chest Physicians. . . . Appointed to the newly created post of vice-president for medical affairs at Hutzel Hospital is **Earnest Booth, MD**, Detroit. . . . **J. Kenneth Altland, MD**, Lansing, was honored with a plaque by the Michigan State Police for 30 years of service as medical director. . . . Recently elected to the board of directors of the Michigan Association of Rural Health Care is **Blake W. H. Smith, MD**, East Lansing. . . . A fourth-year medical student at the University of Michigan, **Rocio Huet**, is the new president of the American Medical Students Association. Ms. Huet hopes to encourage the AMSA Foundation to bolster its support for the association's 12 special interest task forces and will work to promote the leadership skills and ideas of task force coordinators. . . . **Joseph G. Toole, MD**, Ann Arbor, is new associate director, Clinical Therapeutics, Clinical Research Department, Warner-Lambert/Parke-Davis Pharmaceutical Research Division. . . . New executive vice-president of the Upjohn Company is **Theodore Cooper, MD**, Kalamazoo. . . . Recip-

ients of the Bon Secours Hospital Semmes Awards are **Peter Warrington, MD**, and **Lawrence Marten, MD**. The awards are given twice yearly to the house officers who best exemplify the spirit of the Sisters of Bon Secours. . . . **Phyllis O. Helcher, MD**, recently was featured in a *Flushing Observer* article on the role of being a female physician. . . . New chief of staff at Oakwood Hospital, Dearborn, is **Rosser L. Mainwaring, MD**, former president of the Michigan Cancer Foundation. . . . **Alfred Swanson, MD**, Grand Rapids, was the presidential guest speaker at the Japanese Society for Surgery of the Hand which met in Kyoto, Japan. . . . **Williah Weddon**, freelance writer and wife of **Edward R. Weddon, MD**, Stockbridge, has written a new book entitled, "How to Heat and Eat with Woodburning Stoves." In addition to recipes for cooking on a woodburning stove, the book includes tips on how to select and install the stove. . . . A special celebration was held honoring **Harold E. Bowman, MD**, Grand Rapids, for 25 years of service as chief of staff at Saint Mary's Hospital. The celebration, which was held at the hospital, was a reunion of all the medical technologists trained under Doctor Bowman's direction at Saint Mary's. . . . **Harry W. Taylor, MD**, Grosse Ile, was guest of honor at a surprise dinner party given by three generations of a family he has treated for over 36 years. . . . **Donald Trapp, MD**, was the subject of a recent newspaper article in the Hillsdale Daily News. In the article, Doctor Trapp reflects on his 33 years of practice in the Hillsdale area.

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FP **Warren R. Garr, MD** FP
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PD **Marjorie J. Hickman, MD** IM
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Battle Creek, 49017

NM/R **Michael E. Holda, MD** ORS
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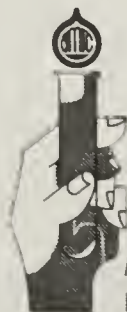
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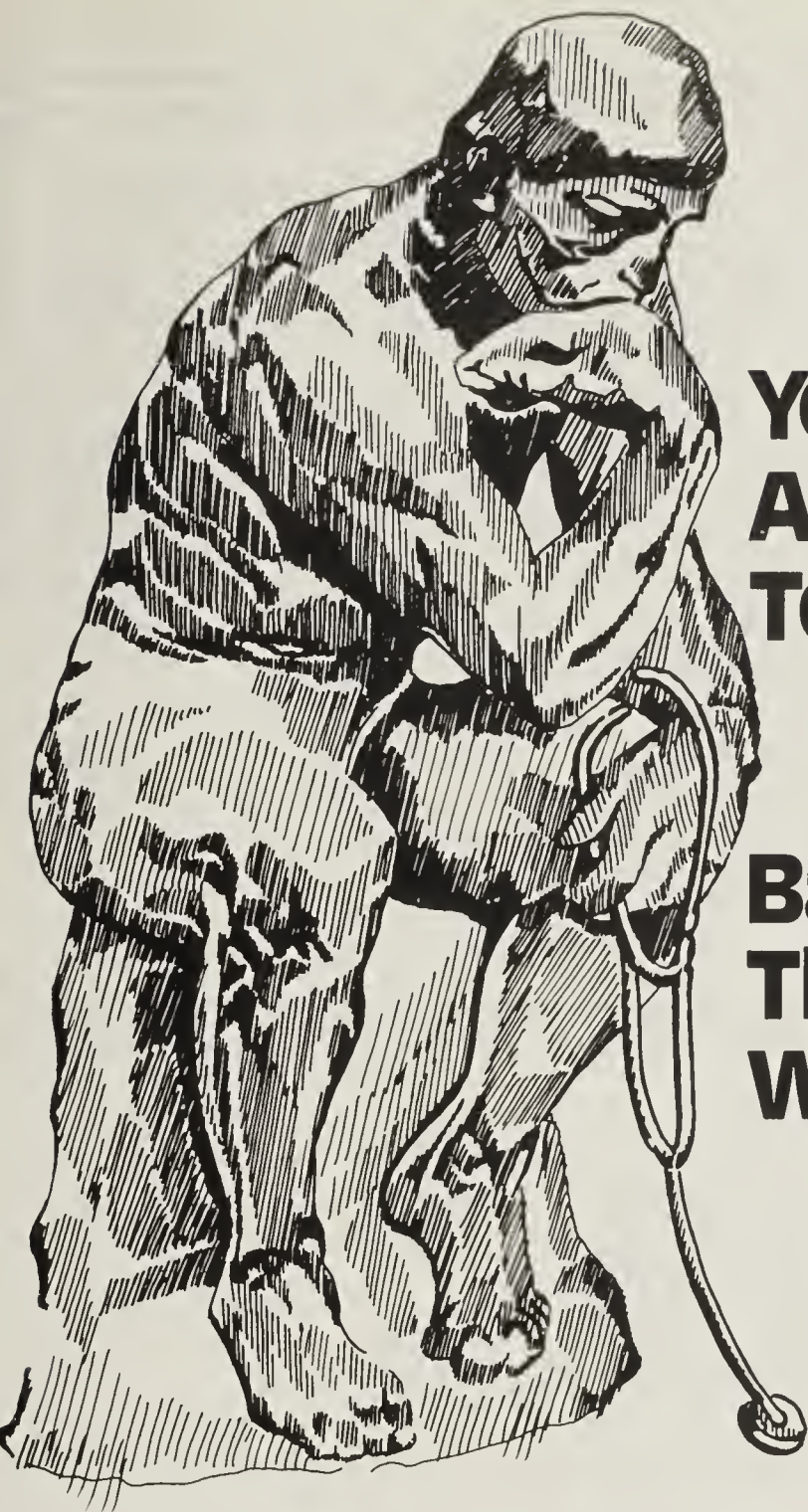
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Robert M. Zimmerman, M.D.

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MSMS has a number of educational materials which Michigan physicians may use to explain a medical condition, steer an interested individual toward a health career or better explain the vagaries of medical practice.

These might include the new MSMS brochure, "To Your Good Health," printed this year to help physicians talk with patients about good health care practices and the reasons for increasing medical care costs. The attractive brown, black and white brochure costs just \$5 per hundred and must be ordered in multiples of 100.

Another recent MSMS offering includes the standup gold tent card which carries the message "I'm worried, too . . . about the costs of medical care. . . ." and goes on to provide an opening for discussion between physicians and patients about medical care costs. This card is available free of charge.

Handsome four-color booklets on William Beaumont's Michigan history are mailed on request to interested people from MSMS headquarters.

Other pamphlets available in quantity from MSMS headquarters include guides to health careers and to materials available on health topics and health careers, published by the MSMS sister organization, the Michigan Health Council.

In addition, MSMS has ready access to AMA films, tapes, slides, books, pamphlets, brochures and other instructional and teaching guides. These are for both physician and public.

TO YOUR GOOD HEALTH



These AMA publications carry titles such as:

"You need a doctor . . . a family doctor . . . before illness strikes! Why wait?"

"Immunization"

"AMA Family Health Record"

"Your blood pressure"

"Helping hands — the challenge of medicine"

"On being an intelligent patient"

"When to call or see your physician."

when to call or see your physician



HELPING HANDS
the challenge of medicine



Interested physicians should contact Mert Scholten at MSMS headquarters for aid in obtaining these helpful materials.

In memoriam: Robert E. Rice, MD

By Herbert A. Auer, East Lansing

Doctor Bob Rice . . .
... wise physician
... loving person
... moving force
... willing worker

So many phrases can be used to describe Robert E. Rice, MD, respected, dedicated leader of the Michigan State Medical Society, Michigan Health Council, Michigan Physicians Mutual Liability Company, American Medical Association, Lions Club, his church, the local schools.

The death of Doctor Rice, at 60, was a shock. He had just participated in the summer meeting of the MSMS Council and he was about to leave for Chicago to chair the Michigan delegation to the AMA House of Delegates. He became ill in his office July 14 while treating patients, was taken to Blodgett Hospital, and died July 16.

Persons who knew and loved Doctor Rice recall different stories. Physicians and friends had seen him perform in so many different roles — and in each case with compassion and thoughtfulness.

He was loved and will be remembered by many because he snowplowed the driveway for his minister, dropped off fruitcakes at Christmas time for many friends, encouraged high school athletes to hit the books, and took off his coat at the MSMS kitchen and boiled sweet corn for the staff.

Leaders in the state and national medical fields for years have called upon Doctor Rice to handle complex, sticky subjects. He presided at MSMS and AMA reference committee meetings, at workshops and at informal sessions with fairness and dignity.

And, Doctor Rice was the stalwart on the AMA Committee on Rural Health, was a progressive voice at the board meetings of the Michigan Physicians Mutual Liability Company, and was an active long-

Mr. Auer is executive vice president, Michigan Health Council. He formerly was deputy director of MSMS, and was on the MSMS staff nearly 20 years.



Doctor Rice

time leader of the Montcalm County Unit of the American Cancer Society, donating space in his office for use by that organization.

Just citing the thoughtful service given by Doctor Rice to MSMS would take many paragraphs. Soon after establishing his practice in Greenville in 1947 he became active in medical organization activities. He was a past president of the Ionia-Montcalm County Medical Society, was chairman many years of the MSMS Committee on Rural Health, was an MSMS delegate to the American Medical Association House of Delegates for 18 years; he was a member of the MSMS House for 24 years, and he performed special assignments on various MSMS committees and task forces.

When MSMS took the leadership in 1976 to organize the Michigan Physicians Mutual Liability Company to help make professional liability insurance available, he became a member of the original Board of Directors, and had been re-elected and held responsible committee chairmanships since.

As chairman of the AMA delegation, he was a prominent member of the MSMS Council since 1976. His reports on AMA activities were succinct and insightful.

A long-time delegate from MSMS to the Michigan Health Coun-

cil, he joined that Board of Trustees in 1972. He served with distinction as the MHC president in 1973, and continued as a member of the Board. He was highly respected among leaders in all health and medical organizations, as he spoke for physicians at MHC conferences and meetings. He was especially supportive of the MHC efforts to expand the Physician Placement Service for rural communities.

Keenly interested in children and young people, Doctor Rice was the Greenville High School team doctor for more than 30 years, a member of the Greenville Board of Education for eight years, and its president for seven years. The community recognized his contributions by naming the Greenville High School gymnasium the "Robert E. Rice Gymnasium."

He was widely known and respected for his efforts with the Lions Club, as a member of the Greenville Club for 33 years, as past president and as District Governor in that area. He was proud of his perfect attendance for 33 years.

Beloved family physician in Greenville, Doctor Rice served as chief medical examiner of Montcalm County and as chief of staff at the United Memorial Hospital in 1953, then again in 1964 and more recently in 1975. He was a member of the Greenville Chamber of Commerce and sang in the choir of The First Congregational Church.

Doctor Rice was born February 11, 1920 in Cedina, Ohio and was graduated from The University of Michigan Medical School.

He was a veteran of both World War II and the Korean War.

Doctor Rice is survived by his wife, Geraldine, three children, three sisters and two grandchildren.

Memorial contributions may be made to the First Congregational Church of Greenville, American Cancer Society or Lions International.

New physicians usually choose one of five specialties, Michigan study shows

By Valerie Merritt, special to Michigan Medicine

Where do new Michigan physicians usually come from?

Where did they receive their training?

What medical specialties are they practicing?

There are a few answers available, thanks to the Michigan Health Council, which has just completed a study based on newspaper clippings about 158 physicians who began practice in Michigan in 1979. This study revealed some interesting and encouraging facts about the new doctors in Michigan.

Out of the 158 doctors, 73 opened private practice with offices located in medical clinics or buildings; 47 joined other doctors in established practices; 24 took positions in hospitals; 10 reopened or took over active practices; and five joined health services and other health care associations.

Five specialties

The study revealed that new physicians tend to specialize in five major categories; family practice, pediatrics, internal medicine, surgery, and obstetrics and gynecology.

Of the 158 doctors, 12 were female and 146 were male. Four of the female doctors are team practicing with their husbands.

Information on the educational background was not available for all of the physicians. Out of 103 physicians, 43 were graduates of one of the medical schools in Michigan, 37 were from out-of-state schools, and 23 were from medical schools in other countries. Out of 99 physicians, 55 did postgraduate training at medical residency programs in Michigan, 41 did their residency training in other states, and three did theirs in foreign countries.

In the study, 24 new physicians were from foreign countries. The

majority of these doctors came from the Philippines, India, Korea and Pakistan.

According to John Ditzhazy, executive of the Statewide House Officers Training Systems in Michigan, doctors who receive training in a specific area usually return to it at a later period in their career. The study confirmed this view, since most of the new physicians had received at least some education and training in Michigan.

Mr. Ditzhazy is presently researching the feasibility of a "physician tracking system." This system would keep track of a doctor throughout his or her medical career. Medical schools do know where their graduates go for postgraduate study, but afterwards no one agency or institution follows the physician. A physician may choose to go into the military service, private practice, or into further specialized training. While most doctors provide patient care, there are a variety of ways a doctor can teach others, do research or serve in administrative positions.

Useful study

According to Herbert Auer, executive vice president of the Michigan Health Council, this study was useful in a number of ways. First, the study shows that many young doctors specialize in family practice and set up private practice. Second, the study reveals that a large number of doctors had received some training in Michigan, which may be one of the reasons they chose Michigan to practice. Finally, the study focuses attention on the need for extensive research of this type.

The Michigan Health Council operates the Physician Placement Service in Michigan, as well as the Dentist Placement Service. The Council has 506 physicians registered and interested in possible

Michigan opportunities. There are 137 communities registered as needing/wanting one or more physicians.



DEATHS

Stanley H. Brown, MD Lake Worth, FL

Stanley H. Brown, MD, Lake Worth, FL., died June 14. He was 83. Doctor Brown received his MD from McGill University Medical School in Montreal in 1920. He practiced for 47 years in the Detroit area. Before his retirement in 1968, Doctor Brown was on the staff of Mt. Carmel Mercy Hospital.

Kenneth M. Coyne, MD Flint

Kenneth M. Coyne, MD, Flint, died July 3 at the age of 66. Doctor Coyne earned his MD from the University of Rochester Medical School in 1940. He was associated with Hurley, McLaren and St. Joseph hospitals.

John F. Failing, Jr., MD Fenton

John F. Failing, Jr., MD, Fenton, died July 5. He was 52. Doctor Failing had been an associate pathologist at Hurley Medical Center for the past 17 years. He received his MD from Wayne State University School of Medicine in 1954. He was a member of the American Society of Clinical Pathology, the College of American Pathology and the Michigan Society of Pathology.

Theodore H. Hunt, MD Gulf Shores, AL

Theodore H. Hunt, MD, Gulf Shores, AL, died June 11 at the age of 78. Before entering medical school, Doctor Hunt taught high school in Minnesota. He earned his MD in 1934 from Wayne State University School of Medicine. Doctor Hunt had served as chief of staff at Deaconess Hospital.

Edward H. Lauppe, MD Grosse Pointe Farms

Edward H. Lauppe, MD, Grosse Pointe Farms, died June 22. He was

81. Doctor Lauppe earned his MD from the University of Michigan Medical School in 1923. Prior to his retirement, Doctor Lauppe served on the staffs of Harper and Children's hospitals.

Howard H. McNeill, MD Bloomfield Hills

Howard H. McNeill, MD, Bloomfield Hills, died June 22 at the age of 84. Doctor McNeill earned his MD from Howard University Medical School in Washington, DC. He was a founding father of the Pontiac Urban League and was Pontiac city commissioner for 10 years. Doctor McNeill was past president of the Michigan Board of Medicine and served on the Oakland Board of Supervisors.

Harry E. Schmidt, MD Phoenix, AZ

Harry E. Schmidt, MD, Phoenix, AZ., died July 16. He was 80. Doctor Schmidt received his MD from the University of Iowa in 1926. He maintained an office in the Fisher Building in Detroit from the building's opening in 1929 until his retirement in 1970. He was also on the staffs of Ford and Women's hospitals.

Clifford B. Taylor, MD Laguna Hills, CA

Clifford B. Taylor, MD, Laguna Hills, Ca., died June 22 at the age of 74. Doctor Taylor earned his MD from the University of Michigan Medical School in 1931. During his service in the U.S. Air Force Medical Corps from 1943 to 1946, Doctor Taylor specialized in tropical medicine. He was medical director of the Albion College health service from 1936 to 1942. He served as a staff member at Albion Community Hospital until his retirement in 1971.

Frank M. Townsend, MD San Diego, CA

Frank M. Townsend, MD, San Diego, CA., died June 1. He was 82. Doctor Townsend received his MD from the University of Michigan Medical School in 1925. He was associated with Grace and Trumbull general hospitals.

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Eli Lilly	479
Medical Protective	496
W. F. Merchant Pharmaceutical	480
Merck Sharp and Dohme ..	466, 467
Mercywood Hospital	504
Merrell National ..	462, 463, 490, 491
Michigan Physicians Mutual Liability Company	501
MSMS Annual Scientific Meeting	477
Health and Human Services	494
Purepac	497
Roche	450, 451, 464, 492, 493, 494, IBC, BC
Sandoz	473
Stat Medical Books	488
Stratton Cheeseman	489
U.S. Air Force	504
Wyeth Labs	481, 482

CLASSIFIED

The rate for each classified advertisement in *Michigan Medicine* is 15¢ per word, with a minimum charge of \$7.50. Copy for classified advertisements should be received not later than the first of the month preceding the month of publication.

Positions open

Marquette, Michigan. Expanding referral center has positions available both immediately and in the future for an allergist and a part-time director of medical education. Also needed are additional physicians in the following specialties: neurologist, dermatologist, nephrologist, urologist, and radiation therapist. Fully equipped hospital with: advanced lab facilities, CT Scanner, active cardiovascular surgery, active participation in the training of MSU medical students, and a family practice residency. Current staff of 79 solo and small group of private practitioners; 87% board certified; average age of active staff is 42. University town on unspoiled Lake Superior with all recreational activities. Send curriculum vitae or call: Executive Director's Office, Marquette General Hospital, Inc., 420 W. Magnetic Street, Marquette, Michigan 49855. 906/228-9440, extension 434.

Rheumatologist Wanted — to join four orthopedic surgeons in a very desirable North Central Wisconsin community with a drawing population of 70,000. Active practice assured, share "on call" provided, research grants available. New clinic facility located within new 35 million dollar hospital complex. Outstanding personal benefit programs, generous guaranteed income. For further information contact: Lloyd Engstrom at (715) 842-3202, or write P.O. Box 1646, Wausau, WI 54401.

Orthopedic Surgeon Needed for Industrial medical evaluation. 40 hour week with excellent benefits including life insurance, malpractice, vacation and car. Fully-equipped modern clinic in major Michigan city. Reply in confidence to Durham Medical Search, 5050-N Statler Office Building, Buffalo, NY, 14202, or call 716/852-5911.

Director of Internal Medicine. Internal medicine residency program director sought for 481-bed community hospital in Southeast Michigan, which is currently involved in a major expansion of its programs and facilities. The hospital's service area includes many affluent suburbs. In addition, it affords ample opportunity for cultural enrichment, both winter and summer recreation, and professional sporting events. St. Joseph Mercy Hospital, Pontiac, presently has 24 residents in internal medicine. Seeking board-certified academic internist whose work would emphasize resident and medical student teaching; and supervision of patient care activities. Subspecialty training preferred. Excellent fringe benefits; salary negotiable. Contact Doctor Lawrence J. Zgliniec, Director of Medical Education, 900 Woodward Ave., Pontiac, Michigan, 48053; or call (313) 858-3230.

Anesthesiologist Wanted to join the Central Wisconsin Anesthesiology, S.C., which consists of three established, hospital based anesthesiologists. All specialties are served including open heart, neuro, obstetrics and gynecology. If interested, phone 715/845-5505, or write to: Central Wisconsin Anesthesiology, S.C., 425 Pine Ridge Blvd., Suite 207, Wausau, WI 54401.

Indiana — Fort Wayne. Emergency Physician needed. Experience and ability to meet board credential requirements desirable. Unique organization, multiple hospital group owned by all the physicians. Profits returned to physicians, not to entrepreneur. Contact American Medical Services Association, Inc., 4400 Broadway, Suite 306, Kansas City, Missouri, 64111. (816) 931-3040.

Locum Tenens: Needed for established pediatric practice in beautiful Marquette, Michigan on Lake Superior in the Upper Peninsula. 50% office and 50% hospital pediatric practice with Level II NICU. Needed August 1980 to June 1981. Contact: Dale C. Alverson, MD, 1414 West Fair Avenue, Marquette, MI 49855. (906) 228-6704 or 228-9440 and page.

Positions With The State Of Michigan — Currently taking applications for positions expected to be available in the future. Primarily interested in board certified or board eligible internists with cardiology background. Office locations in Southfield, Lansing, and Traverse City. Also considering an office in Kalamazoo. Salary in 50's with approximately 40% fringe benefits. An equal opportunity employer. All enquiries treated confidentially. For further details please write: Disability Determination Service, P.O. Box 30011, Lansing, MI 48909, or call collect: Harry D. Nesmith, MD, Chief Medical Consultant (517) 373-7830. In Michigan, call toll free 1-800-292-2710.

Positions wanted

Graduating Family Practice Resident available June 1981. Seeking opportunity in group family practice in western Michigan. Will respond personally to all inquiries. Please reply to: Practice Opportunity, 12995 E. Outer Dr., Detroit, MI 48824.

Locum Tenens work wanted — Family and General Practice, open availability — T.C. Kolff, MD. 801-566-1666.

Miscellaneous

For Rent or Lease: Daytona Beach, Florida. New luxurious 2 bedroom, 2 bath decor-furnished condominium overlooking Atlantic Ocean. Swimming pool, 2 saunas, party room, shuffleboards, tennis, golf. Weekly, monthly discount. Call 313/329-7000.

Space For Lease. Wayne Commons Shopping Center — 2,000-4,000 sq. ft. on Michigan Ave. near Wayne Rd. in the city of Wayne. Well populated areas, ample parking, reasonable rent. Gordon Management Company, Inc. 313/647-7171.

Metal Plaque — Honorary certificates, diplomas photos, etc. perfectly reproduced in bright silver toned metal with black lettering, all the clarity of the original yet immune to deterioration. Mounted on richly finished walnut base 10 x 12 for only \$39.95. Allow four weeks. Perma-Plaque, 553 Lincoln, Grosse Pointe, MI, 48230, 313/884-9399.

Burt Lakes First Condominium. Directly on beautiful Burt Lake highbanks, spectacular view of the entire length of Burt Lake. Modern, luxury, two & three bedroom units. Near Boyne

ski hills. \$92,000-\$96,500. Furnished unit rentals available for vacation year round. A. K. Smith & Son Realty, Box 578, Indian River, MI 49749. 616/238-9338. Michigan toll free calls 1-800-632-7179.

#3099 Northern Michigan Retreat — One of the finest 80 acre parcels in all of Northern Michigan. Two bedroom winterized log cottage, furnished, 2 stall garage. Excellent cross country ski trails, snowmobiling, hunting. Just off I-75 between Indian River and Wolverine. \$52,000. Terms. A. K. Smith & Son Realty, Box 578, Indian River, MI 49749. 616/238-9338. Michigan toll free calls 1-800-632-7179.

Boater Paradise. Directly on the Indian River, part of Michigan's famous inland waterway system. Beautiful 50 year old remodeled home. 4 bedrooms, circular fireplace. Nice landscaped yard, deep boatwell. \$79,900 terms. A. K. Smith & Son Realty, Box 578, Indian River, MI 49749. 616/238-9338. Michigan toll free calls 1-800-632-7179.

Burt Lake Cottage — Secluded two bedroom cottage — private road access. 100 feet well wooded frontage. \$57,000. A. K. Smith & Son Realty, Box 578, Indian River, MI 49749. 616/238-9338. Michigan toll free calls 1-800-632-7179.

Burt Lake — One of the lakes finest locations . . . 200 feet of lake frontage. 150 feet of Sturgeon River frontage. Private blacktop road access. Modern 3 bedroom ranch type home, nice fireplace, new garage. Many extras. \$115,000. A.K. Smith & Son Realty, Box 578, Indian River, MI 49749. 616/238-9338. Michigan toll free calls 1-800-632-7179.

For Rent — Hilton Head Island, SC — Luxurious 2 bedroom, 2 bath condominium. Brand new, completely furnished. Lagoon backyard, one minute to beach. Walk to tennis court, golf course, pool at exclusive Palmetto Dunes Resort. By the week \$500.00. Call 313-695-0356.

Microfilming: Let us microfilm your X-ray films and save you office space; at the same time get extra money out of the silver from the films. Write or call Recographics Services, Inc., 17350 West Ten Mile Road, Southfield, Michigan 48075. Tel. (313) 552-0557.

Luxury Chalet: perfect for 2-family or corporate ownership, accommodates 12-14. Fully furnished, 5 double bedrooms, 3 full baths, in leading northern Michigan all-season resort. 18 hole golf course, tennis, skiing, water sports, hunting, fishing, near excellent airport. Terms negotiable. Owner — (616) 587-9241.

Sanibel Island, Fla. Luxurious 2 bedroom, 2 bath condominiums on Gulf. Completely furnished including linens. Miles of uncrowded white sand beaches, fringed by lush tropical foliage, wild flowers, graceful sea oats and flowering trees. All amenities including pool, tennis, golfing, fishing, boating, sailing, bicycling and bird watching. Weekly, monthly discount. 313-645-5498.

Traverse City Michigan — Plenty of glass, magnificent modern 4 bedroom, 3 bathrooms, 2 fireplace home, living room, dining room, family room overlooking Lake Leelanau on Timberlee ski resort. Weekly or monthly, open December thru April. Call Cindy Thompson 313-882-7060 or write 16840 E. Warren, Detroit, MI 48224.



Reimbursement by full service benefit — what are the problems?

By John R. Ylvisaker, MD, MSMS President

This essay is one of a series examining three major issues which Doctor Ylvisaker feels require active, responsible leadership for change by the medical profession. The three issues are: reimbursement, health planning, and regulation.

In my last discussion I expressed my strong opinion that the time has come to change our way of paying for health care. But why the big talk about need for change? What's the matter with the full service benefit system of payment that prevails? What are the problems?

Major problems

Let's look more closely:

First and foremost is the problem of conceptual design. The "system," whether Medicare, Medicaid, Blue Cross Blue Shield, private insurance or capitation plan, is constructed on the premise that everyone has the right of full access to as much health care as the individual feels a need for, and that cost should be eliminated as a possible deterrent to obtaining medical care.

Building on this concept, the system is designed for the patient to obtain care with little or no out-of-pocket cost, with no first-dollar responsibility.

Secondly, the system is designed to be funded by contributions (premiums) paid not by the patient but by an employer or by government without knowledge, concern, or responsibility for the amount on the part of the patient. And, lastly, "premiums" not paid by the patients directly are free of tax. Thus all incentives are elim-

inated for the patient to care how much the "insurance" costs or how cost-efficient the insurance plan might be.

So what is the natural consequence? The patient has no awareness or concern for unit cost or aggregate cost of service or for the volume of services used.

The secondary natural consequence is that the provider of services, acting at the expectation of the patient and knowing that the cost of any and all services will probably be paid by a "faceless" system which will usually not have to be eyeballed, provides these services in volume and frequency without serious regard for cost.

Thus health care facilities are encouraged to over-invest and over-expand, and physicians and patients are encouraged to over-utilize.

Less obvious is that the entire delivery system is encouraged to be economically lazy, sloppy, and sometimes even dishonest. Hospitals have little incentive for true "profit and loss" accountability, since cost of operation will always be paid for either by payment of actual charges or coverage of losses by charges which reflect the "cost of operation." Physicians lose cost-consciousness in their approach to choice of diagnostic studies, therapeutic modalities or agents, and sites of care (office, emergency room, hospital in-patient). Patterns of practice are subconsciously adapted to the source and level of payment. Billing practices are structured, and sometimes manipulated, to

achieve the level of maximum payment. And, since bills are usually not subject to scrutiny by the user of the services, they are less accurate and more subject to error.

Freedoms lost

So, what's the big deal? Everyone who thinks twice already knows all about too many hospital beds, too much hospitalization, too much doctoring, too high costs, too much technology, and on and on. But there is a big deal:

The full service benefit system of reimbursement has eliminated all normal marketplace incentives. It has shifted control of the marketplace from the health professionals to the new buyers (payers) of health care. And the system is causing a progressive loss of basic professional freedoms — free choice of physician, right and responsibility to make appropriate clinical decisions, right to set equitable fees for service.

The truism voiced by Thomas Jefferson is coming home to roost in the health care delivery system: Who controls a man's livelihood, controls the man. Inevitably, the way medical care is paid for and by whom it is paid will determine how the delivery system operates and who is in control.

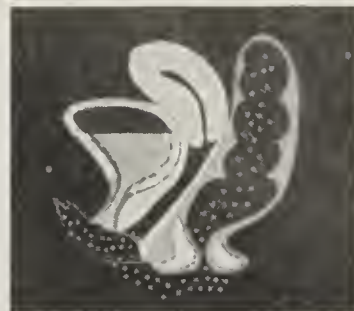


For recurrent attacks of urinary tract infection in women

BactrimTM DS Double Strength Tablets

Each tablet contains 160 mg trimethoprim and 800 mg sulfamethoxazole.

Just one tablet b.i.d. for 10 to 14 days



- Action at urinary/vaginal/lower bowel sites helps eliminate reservoirs of infecting organisms
- Distinctive antibacterial action plus wide spectrum helps eradicate recurrent UTI
- Low incidence of bacterial resistance in community practice

Before prescribing, please consult complete product information, a summary of which follows:

Indications and Usage: For the treatment of urinary tract infections due to susceptible strains of the following organisms: *Escherichia coli*, *Klebsiella-Enterobacter*, *Proteus mirabilis*, *Proteus vulgaris*, *Proteus morganii*. It is recommended that initial episodes of uncomplicated urinary tract infections be treated with a single effective antibacterial agent rather than the combination. Note: The increasing frequency of resistant organisms limits the usefulness of all antibacterials, especially in these urinary tract infections.

Also for the treatment of documented *Pneumocystis carinii* pneumonitis. To date, this drug has been tested only in patients 9 months to 16 years of age who were immunosuppressed by cancer therapy.

The recommended quantitative disc susceptibility method (*Federal Register*, 37:20527-20529, 1972) may be used to estimate bacterial susceptibility to Bactrim. A laboratory report of "Susceptible to trimethoprim-sulfamethoxazole" indicates an infection likely to respond to Bactrim therapy. If infection is confined to the urine, "Intermediate susceptibility" also indicates a likely response. "Resistant" indicates that response is unlikely.

Contraindications: Hypersensitivity to trimethoprim or sulfonamides; pregnancy; nursing mothers; infants less than two months of age.

Warnings: Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia with purpura in elderly patients on certain diuretics, primarily thiazides. Sore throat, fever, pallor, purpura or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended; therapy should be discontinued if a significantly reduced count of any formed blood element is noted.

Precautions: Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function.

Adverse Reactions: All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. **Blood dyscrasias:** Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. **Allergic reactions:** Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. **Gastrointestinal reactions:** Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea and pancreatitis. **CNS reactions:** Headache,

- Convenient b.i.d. dosage provides day-and-night antibacterial control
- Contraindicated during pregnancy and the nursing period. During therapy, maintain adequate fluid intake; perform CBC's and urinalyses with microscopic examination.

peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. **Miscellaneous reactions:** Drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L. E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.

Dosage: Not recommended for infants less than two months of age.

Urinary Tract Infections: Usual adult dosage—1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 10-14 days.

Recommended dosage for children—8 mg/kg trimethoprim and 40 mg/kg sulfamethoxazole per 24 hours, in two divided doses for 10 days. A guide follows:

Children two months of age or older

Weight		Dose—every 12 hours	
lbs	kgs	Teaspoonfuls	Tablets
20	9	1 teasp. (5 ml)	½ tablet
40	18	2 teasp. (10 ml)	1 tablet
60	27	3 teasp. (15 ml)	1½ tablets
80	36	4 teasp. (20 ml)	2 tablets or 1 DS tablet

For patients with renal impairment:

Creatinine Clearance (ml/min)	Recommended Dosage Regimen
Above 30	Usual standard regimen
15-30	½ the usual regimen
Below 15	Use not recommended

***Pneumocystis carinii* pneumonitis:** Recommended dosage: 20 mg/kg trimethoprim and 100 mg/kg sulfamethoxazole per 24 hours in equal doses every 6 hours for 14 days. See complete product information for suggested children's dosage table.

Supplied: Double Strength (DS) tablets, each containing 160 mg trimethoprim and 800 mg sulfamethoxazole, bottles of 100; Tel-E-Dose[®] packages of 100. Tablets, each containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500; Tel-E-Dose[®] packages of 100; Prescription Paks of 40, available singly and in trays of 10. Oral suspension, containing in each teaspoonful (5 ml) the equivalent of 40 mg trimethoprim and 200 mg sulfamethoxazole, fruit-licorice flavored—bottles of 16 oz (1 pint).



Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

Please see back cover.

Her next attack of cysti

the BactrimTM 3-system counterattack



ROCHE

Bactrim has shown high clinical effectiveness in recurrent cystitis as a result of its wide spectrum and distinctive antimicrobial action in the urinary, vaginal and lower intestinal tracts.

The probability of recurrent urinary tract infection appears to be enhanced by the establishment of large numbers of *E. coli* or other urinary pathogens on the vaginal introitus. The trimethoprim component of

Bactrim diffuses into vaginal fluid in effective concentrations, thus combating migration of pathogens into the urethra.

Studies have shown that Bactrim acts against *Enterobacteriaceae* in the bowel without the emergence of resistant organisms. Thus, Bactrim reduces the risk of introital colonization by fecal uropathogens. It has *no* significant effect on other normal, necessary intestinal flora.

Bactrim fights uropathogens in the urinary tract/vaginal tract/lower intestinal tract

Please see reverse side for summary of product information.

Registration form
appears on page 19

MEDIGRAM

Here is your program, Doctor . . . for the MSMS Annual Scientific Meeting

Gain new knowledge!
Test your theories!
Learn a new technique!
Join your colleagues!

Each of these opportunities is yours, Doctor, when you attend the 1980 Annual Scientific Meeting of the Michigan State Medical Society Nov. 18-19-20 at the Hyatt Regency Dearborn.

This issue of the MSMS Medigram newsletter is your personal advance copy of the full scientific meeting program, which annually attracts nearly 2,000 Michigan physicians.

The registration form is on page 19, and provides full information on course choices, fees and luncheon reservations.

"Advance registration is important to ensure a place in the courses of your choice," stresses Samuel M. McMahon, MD, Lansing, Annual Scientific Meeting chairman.

This issue describes all 54 courses, and includes times, course titles, sponsors, course directors, speakers or faculty members, their subjects and professional titles.

18 Category I credits

Each of the half-day courses awards three Category I credits. It is possible to earn 18 credits by attending the entire program. In addition, all but two of the courses are approved for prescribed credit by the American Academy of Family Physicians.

Also in this issue are special ar-

ticles about the two-day Advanced Cardiac Life Support Program being presented Wednesday and Thursday by the Michigan Chapter, American College of Emergency Physicians.

The 16-hour course is a nationally-recognized training and certification program and is limited in registration. A Basic Cardiac Life Support course is offered Tuesday afternoon for those physicians who have not been certified before going on to the advanced course.

In addition, this issue contains information about luncheons, receptions and business meetings planned by the Michigan specialty societies during the MSMS Annual Scientific Meeting.

Virtually every major Michigan specialty society has been involved in planning courses during the Annual Scientific Meeting. Specialists will find courses designed with them in mind, while generalists will benefit from the practical approach taken in each course and the emphasis on valuable information for use in day-to-day practice.

"The program is excellent, inexpensive, diversified and practical," says Doctor McMahon, chairman for the past two years of the Annual Scientific Meeting.

"The main advantages are that one can learn from recognized experts in a stimulating environment and can be brought up to date painlessly," he continues.

Doctor McMahon and his task

force are introducing some courses this year during which the participants are invited to present actual cases for discussion by the experts. Another special program, designed to help physicians become better expert witnesses, will include simulated courtroom situations and testimony.

Hyatt Regency again

The bustling, luxurious Hyatt Regency Dearborn again is the facility for the three days of MSMS CME courses. Educational sessions, MSMS registration area and exhibit hall are grouped in a new east wing of the building for easy maneuvering by physicians and MSMS staff.

The Hyatt will offer a luncheon each day in the MSMS exhibit hall for physicians attending courses. In addition the Hyatt has several excellent restaurants to choose from.

There is much of interest in the immediate area, including Greenfield Village, Henry Ford Museum and the tri-level Fairlane Town Center shopping mall, which is connected to the hotel by the smooth, enclosed automatic transportation service.

Again this year, the tuition of \$5 per credit hour for MSMS members, \$10 per credit hour for non-members, and \$5 per course for residents will help cover MSMS expenses for the Scientific Meeting.

Any physicians with questions may telephone MSMS at 517/337-1351 and ask for Sherry Fent.

Complete and return registration form on page 19

53 courses offer 3 hours each of Category I credit

Courses Tuesday morning, Nov. 18

All courses run from 8:30 to noon with half-hour break

☐ **Care of the Elderly**

PRESENTED BY: Department of Family Practice, Michigan State University College of Human Medicine

Primary care physicians see a large percentage of geriatric patients, yet may not feel they are adequately prepared to practice health screening and early detection on a routine basis with their elderly patients who are ambulatory and not seriously ill. This course is meant to address this need. It will focus on three aspects of care of the elderly: 1) understanding the normal physical, psychological and sociological changes that occur with aging; 2) demonstration of routine health monitoring through history and physical exam; and 3) decision making on nursing home placement. The methods of presentation will include lecture — slide presentation and small group problem-solving exercises. Participants can expect to enrich their knowledge of the normal changes that occur with aging; to obtain a protocol for routine health screening of the elderly; and to obtain practice in looking at the many factors which impinge on the decision for nursing home placement.

COURSE DIRECTOR: Roy J. Gerard, MD, Professor and Chairman, Department of Family Practice, Michigan State University College of Human Medicine

PRESIDING: James G. O'Brien, MD, East Lansing

SPEAKERS/SUBJECTS:

James G. O'Brien, MD, Associate Professor and Associate Chairman, Department of Family Practice, and Director, Family Practice Residency, Michigan State University College of Human Medicine

"Protocol for Routine Assessment of the Elderly Patient"

Anne Cunningham, PhD, Assistant Professor, Department of Family Practice, Michigan State University College of Human Medicine

"Decision Making in Nursing Home Placement Using Family and Community Resources"

Mary H. Kroger, RSM, PhD, Associate Professor, Department of Community Health Science, Michigan State University College of Human Medicine

"Normal Physical, Psychological and Sociological Changes that Occur with Aging"

☐ **CME Implementation in Community Hospitals**

PRESENTED BY: Michigan Association for Medical Education

This course presents practical information about establishing quality continuing medical education programs in community hospitals. As a result of attending this course the participants will: a) know the key components to an effective community hospital CME program; b) practice an effective approach to planning community hospital CME program; c) review effective informational methods for community hospital CME program; d) identify effective follow up and feedback mechanism for community hospital CME programs.

COURSE DIRECTOR: Floyd Pennington, PhD, Ann Arbor

PRESIDING: Doctor Pennington

SPEAKERS/SUBJECTS:

Roderick MacDonald, MA, Community Educator, University of Michigan Towsley Center for Continuing Medical Education

"Key Components in a Community Hospital Continuing Medical Education Program"

Floyd Pennington, PhD, Director, Office of Continuing Medical Education, University of Michigan Towsley Center for Continuing Medical Education

"Practical Planning for Community Based Continuing Medical Education"

Roland G. Hiss, MD, Director, Office of Extramural Education, University of Michigan Towsley Center for Continuing Medical Education

"Practical Methods for Community Based Continuing Medical Education"

Roderick MacDonald

"Feedback and Follow-Up: Key Components for Successful Continuing Medical Education"

Victor Rozas, MD, Staff Physician, Gratiot Community Hospital, Alma

(Reacting to each presentation from his perspective in the community hospital.)

☐ **Current Concepts and Practical Therapeutic Approach to Non-Hodgkins Lymphoma**

PRESENTED BY: Department of Oncology, Wayne State University School of Medicine

This course will provide the primary care physician with an outline of the natural history and current concepts in the treatment of non-hodgkins lymphoma. Topics covered include: 1) histopathologic classification; 2) stepwise staging procedures; 3) role of radiation therapy; 4) role of chemotherapy. Case presentations with audience participation will follow. Upon course completion, the physician will comprehend the clinical presentation and assessment of the patient for treatment management.

COURSE DIRECTOR: Voravit Ratanatharathorn, MD, Detroit

PRESIDING: Doctor Ratanatharathorn

SPEAKERS/SUBJECTS:

Roman Franklin, MD, Assistant Professor, Department of Oncology, Wayne State University School of Medicine; Harper Hospital, Detroit

"Staging Assessment"

Voravit Ratanatharathorn, MD, Assistant Professor, Department of Oncology, Wayne State University School of Medicine; Harper Hospital, Detroit

"Clinical Pathologic Correlations"

Jeannie Kinzie, MD, Associate Professor, Department of Radiation Therapy, Wayne State University School of Medicine; Harper Hospital, Detroit

"Role of Radiation Therapy"

Tuesday morning/continued

Chatchada Karanes, MD, Assistant Professor, Department of Oncology, Wayne State University School of Medicine; Harper Hospital, Detroit

"Role of Chemotherapy"

☐ Denial in Alcoholism, Substance Abuse and Mental Health

PRESENTED BY: MSMS Committee to Assist Impaired Physicians

This course is designed to permit physicians with responsibilities for institutional, practice-related, industrial clinic, medical society, hospital-based, or community programs to assist persons with diseases characterized by massive denial to ask questions of experts in the field. A panel of seasoned experts will be available to answer questions concerning the recognition of and techniques available to deal with the problems of patient denial that prevent or delay needed treatment.

COURSE DIRECTOR: Russell F. Smith, MD, Brighton

PRESIDING: Doctor Smith

SPEAKERS/SUBJECTS:

Russell F. Smith, MD, MSMS Committee to Assist Impaired Physicians and Medical Director, Brighton Hospital and Guest House Sanitariums; **Richard Morin, MD**, MSMS Committee to Assist Impaired Physicians and Medical Director, Brighton Hospital; **Stephen C. Mason, III, MD**, MSMS Committee to Assist Impaired Physicians, MPS Committee on the Well Being of Physicians, and Chairman, Washtenaw County Medical Society Committee on the Well Being of Physicians

"Seeing Illness Through a Wall of Denial"

Doctors Mason, Morin and Smith

"Intervening and Motivating the Denying Patient"

☐ Management of Problems in Office Gynecology

PRESENTED BY: Michigan Society of Obstetricians and Gynecologists

This course will provide practical material to assist in management of fundamental gynecologic inquiries and problems encountered in daily practice. At the completion of the course, physicians will be able to screen and perceive problems related to benign breast disease and mammography, as well as learn basics for treating common adolescent gynecologic problems. Additionally, sexual history-taking with physician response interpretation will be reviewed. Finally, the physician will learn guidelines for evaluating and counseling the infertile patient in the office setting.

COURSE DIRECTOR: Bruce H. Drukker, MD, Detroit

PRESIDING: Doctor Drukker

SPEAKERS/SUBJECTS:

Bruce H. Drukker, MD, Chairman, Department of Gynecology-Obstetrics, Henry Ford Hospital, Detroit

"Breast Disease and the Gynecologist"

Richard E. Smith, MD, Senior Staff Physician, Department of Gynecology-Obstetrics, Henry Ford Hospital, Detroit

"Management of Common Adolescent Gynecologic Problems"

William Anderson, MD, Senior Staff Physician, Department of Gynecology-Obstetrics, Henry Ford Hospital, Detroit

"Physician Interpretation and Evaluation of the Sexual History"

William H. Pfeffer, MD, Senior Staff Physician, Department of Gynecology-Obstetrics, Henry Ford Hospital, Detroit

"Office Evaluation of the Infertile Patient"

☐ Multi-Disciplinary Approach to Back Pain

PRESENTED BY: Department of Neurological Surgery and Neurology, Henry Ford Hospital

This course is intended to help the practicing physician dealing with back pain understand the differential diagnosis and its routine examination. The course will explore common orthopaedic causes such as spondylolisthesis, scoliosis, or congenital abnormalities, and neurological causes such as radicular pain from lumbar disc and osteoarthritis. Respective treatments will be discussed. The type and value of physical therapy and physiatry in management of back pain will be reviewed, and finally, the management of chronic pain will be discussed. Time for discussion will be provided and participants are encouraged to bring along questions regarding their own cases.

COURSE DIRECTOR: James I. Ausman, MD, Detroit

PRESIDING: Doctor Ausman

SPEAKERS/SUBJECTS:

Edwin Guise, MD, Chairman, Department of Orthopaedics, Henry Ford Hospital, Detroit

"Back Pain – Common Orthopaedic Causes"

Dietrich Blumer, MD, Chairman, Department of Psychiatry, Henry Ford Hospital, Detroit

"Back Pain – Chronic Pain, Psychiatric Aspects"

Glenn W. Kindt, MD, Acting Chairman, Division of Neurosurgery, University of Michigan Medical School

"Back Pain – Common Neurosurgical Causes"

Robert G. Wiencek, MD, Corporate Medical Director, General Motors Corporation, Detroit

"Back Pain – What It Means to Industry"

Joseph Honet, MD, Chairman, Department of Rehabilitation Medicine, Sinai Hospital of Detroit

"Back Pain – Physiatrists' Options"

James I. Ausman, MD, PhD, Chairman, Department of Neurological Surgery and Neurology, Henry Ford Hospital, Detroit

"Differential Diagnosis of Back Pain"

☐ Occupational Medicine

PRESENTED BY: Michigan Occupational Medical Association

This course is designed to provide a comprehensive review of general preventive medicine and occupational medicine. It is of primary interest to physicians preparing for medicine or others who are actively practicing in these fields, as well as to those with a general interest in learning more about these areas. This course will offer a review of general preventive medicine, emphasizing fundamentals of public health administration, biometry, epidemiology, and environmental health. It will offer a review of occupational medicine with emphasis on the toxic effects of metals, plastics, and pesticides, diseases of the lungs and skin, practical aspects of measurements, and effects of physical hazards including noise and vibration.

COURSE DIRECTOR: Lucius C. Tripp, MD, Milford

PRESIDING: Doctor Tripp

Tuesday morning/continued

SPEAKERS/SUBJECTS:

Robert G. Wiencek, MD, Corporate Medical Director, General Motors Corporation, Detroit

"Wood Shop Model Workers"

Lucius C. Tripp, MD, President-Elect, Michigan Occupational Medical Association and Regional Divisional Director, GM Proving Ground, Milford

"Functional Relationship Between Pre-Employment Physical and Job Performance"

□ Office Management of Common Pediatric Problems

PRESENTED BY: Michigan Chapter, American Academy of Pediatrics

This course will consist of lecture presentations followed by discussion of specific cases and problems submitted by the participants. There are several subjects we hope to discuss in the broad area of common pediatric problems, including office management of seizure disorders, evaluation of the child with short stature, the current status of prenatal diagnosis and the management of common orthopaedic problems. We hope to review these subjects with participants and discuss specific cases they have encountered in their own practices.

COURSE DIRECTOR: Lester Weiss, MD, Detroit

PRESIDING: Doctor Weiss

SPEAKERS/SUBJECTS:

David C. Leach, MD, Pediatric Endocrinologist, Henry Ford Hospital, Detroit; Clinical Instructor of Internal Medicine, University of Michigan Medical School

"Office Evaluation of the Child with Short Stature"

Lester Weiss, MD, Chairman of Pediatrics and Director, Cytogenetics Laboratory and Genetic Counseling Clinic, Henry Ford Hospital, Detroit; Clinical Professor of Pediatrics, University of Michigan Medical School

"Current Status of Prenatal Diagnosis"

Hugh F. Walker, MD, Child Neurologist, Department of Pediatrics, Henry Ford Hospital, Detroit; Clinical Instructor, University of Michigan Medical School

"Office Management of Seizure Disorders: Current Concepts"

E. Dennis Lyne, MD, Division Head, Pediatric Orthopaedic

Surgery and Director, Multidisciplinary Care Clinic, Henry Ford Hospital, Detroit; Clinical Instructor in Surgery, University of Michigan Medical School

"Office Management of Common Orthopaedic Problems"

□ The Wet Ear — Diagnosis and Treatment for Primary Care Physicians

PRESENTED BY: Department of Otolaryngology, Wayne State University School of Medicine

The draining ear accounts for one of the more frequent reasons to visit the primary care physician's office and this condition remains a formidable problem for the practicing physician despite the advent of antibiotics. Indeed, while the incidence of complications from acute otitis media are decreasing, the complications of chronic otitis media have not met those same expectations. It is intended through participation in this program that the physician's capabilities in recognition and management of these problems will be enhanced. The course will provide the various manifestations of the draining ear, rationale of diagnosis, and management. Through participation in this program, skills in recognition and practical management of the more common problems of suppurative and non-suppurative chronic ear disease will be enhanced. Busy practicing physicians all too frequently encounter mundane symptoms and yet these mundane symptoms often reflect more serious disorders than expected. By reviewing the pitfalls of familiarity and bringing to the surface current methods of diagnosing and treatment, it is intended that the participant will enhance his skills and make attendance worthwhile.

COURSE DIRECTOR: Arnold M. Cohn, MD, Detroit

PRESIDING: Doctor Cohn

SPEAKERS/SUBJECTS:

Sean B. Peppard, MD, Assistant Professor, Department of Otolaryngology, Wayne State University School of Medicine

"Chronic External Ear Infections"

Arnold M. Cohn, MD, Professor and Associate Chairman, Department of Otolaryngology, Wayne State University School of Medicine

"Serous Otitis Media — Acute and Chronic Effusion"

Dieter Wendling, MD, Clinical Assistant Professor, Department of Otolaryngology, Wayne State University School of Medicine

"Chronic Suppurative Otitis Media — Diagnosis and Management"

Royal C. Hayden, MD, Clinical Associate Professor, Department of Otolaryngology, Wayne State University School of Medicine

"Complications of Chronic Suppurative Otitis Media"

Courses Tuesday afternoon, Nov. 18

All courses run from 1:30 to 5 p.m. with half-hour break

☐ **Basic Life Support**

PRESENTED BY: Michigan Chapter, American College of Emergency Physicians

This course is being offered for those physicians who are not currently certified in basic life support and who may wish to continue with the advanced cardiac life support courses. It will consist of basic lectures, including management of the airway and cardiac massage. Time will be provided for a practice session on the manikins, but prior CPR practice is highly recommended.

COURSE DIRECTOR: Craig E. Downs, DO, Director of Emergency Medical Services, Lansing General Hospital

COORDINATOR: Shirley A. Bader, RN, Lansing General Hospital

FACULTY:

Karren K. Foster, LPN, Bay Medical Center, Bay City; Kathi Mostek, RN, Bay Medical Center, Bay City; Margo Roedel, RN, Bay Medical Center, Bay City; Sandy Shutt, RN, Bay Medical Center, Bay City

☐ **Brief Psychotherapy by the Primary Physician-Psychoanalyst Team**

PRESENTED BY: Michigan Psychoanalytic Society

The knowledge gained through psychoanalysis is applicable to the mental functioning of all people. By applying this knowledge, the primary care physician can identify those patients suffering from relatively superficial mental disturbances which are reactive either to physical illness, or to life situations and characterized by physical symptoms. In consultation with a psychoanalyst, the physician can identify the basic disturbing elements and develop a therapeutic plan of brief duration. The primary care physician who already has an established positive relationship with the patient can then undertake the supportive psychotherapy, consulting the psychoanalyst when necessary. This will truly be a "wet clinic" consisting only of an introduction and case demonstration followed by case material furnished by the attendees. All those signing up for this course are urged to bring in their own cases for discussion with the instructors.

COURSE DIRECTOR: Lawrence P. Tourkow, MD, Huntington Woods

PRESIDING: Doctor Tourkow

SPEAKERS:

Lawrence P. Tourkow, MD, Chief, Division of Gynecologic Psychiatry, Department of Obstetrics and Gynecology, Wayne State University School of Medicine; Lecturer, Michigan Psychoanalytic Institute, Southfield

Richard Ruzumna, MD, Clinical Assistant Professor, Department of Psychiatry, Wayne State University School of Medicine; Faculty, Michigan Psychoanalytic Institute, Southfield

Linn Campbell, MD, Director of Residency Training, Detroit Psychiatric Institute; Member, Michigan Psychoanalytic Society, Southfield

Charles H. Wright, MD, Clinical Assistant Professor, Department of Obstetrics and Gynecology, Wayne State University School of Medicine

☐ **Chronic Abdominal Pain**

PRESENTED BY: Department of Medicine, Michigan State University College of Human Medicine

The problem of the patient with chronic abdominal pain will be addressed from a multi-dimensional perspective. The anatomical and pathophysiological aspects will first be explored and then the psychosocial components will be discussed. An internist's and a surgeon's approaches to the problem will be presented, followed by psychological management techniques for chronic pain. Following this background, members of the panel as well as the audience will briefly present cases of patients with chronic abdominal pain for discussion and advice.

COURSE DIRECTOR: David S. Greenbaum, MD, East Lansing

PRESIDING: Doctor Greenbaum

SPEAKERS/SUBJECTS:

David S. Greenbaum, MD, Professor of Medicine, Department of Medicine, Michigan State University College of Human Medicine

"Overview"

Howard A. Dean, DO, Assistant Professor of Medicine, Michigan State University College of Osteopathic Medicine

"The 'Anatomy' and Pathophysiology of Abdominal Pain"

James E. Mayle, MD, Assistant Professor of Medicine, Department of Medicine, Michigan State University College of Human Medicine

"The 'Anatomy' and Pathophysiology of Abdominal Pain"

Sumer Verma, MD, Professor of Psychiatry, Michigan State University College of Human Medicine

"Psychosocial Aspects of Pain"

William O. Dobbins, III, MD, Professor of Medicine, University of Michigan Medical School, VA Medical Center, Ann Arbor

"The Internist's Viewpoint"

Kurt M. Carter, MD, Assistant Professor of Surgery, Michigan State University College of Human Medicine

"The Surgeon's Perspective"

William W. Farquhar, PhD, Chairman, Counseling Psychology Interest Group, Michigan State University

"Psychological Management of Chronic Pain"

☐ **Current Management of Renal Failure**

PRESENTED BY: Division of Nephrology, Henry Ford Hospital, Detroit

The objectives of this course are to promote a reasonable understanding of new approaches to patients in chronic renal

Tuesday afternoon/continued

failure. Using case histories as the basis for discussion, the emphasis will be placed on conservative management although dialytic therapies, including CAPD (continuous ambulatory peritoneal dialysis) will be considered. Teachers will rotate from table to table so that each group of 8-15 physicians will hear a variety of points of view.

COURSE DIRECTOR: Nathan W. Levin, MD, Detroit

PRESIDING: Doctor Levin

SPEAKERS:

Nathan W. Levin, MD, Head, Division of Nephrology, Henry Ford Hospital, Detroit

Pedro Cortes, MD, staff physician, Division of Nephrology, Henry Ford Hospital, Detroit

Francis Dumler, MD, staff physician, Division of Nephrology, Henry Ford Hospital, Detroit

K. K. Venkatachalam, MD, staff physician, Henry Ford Hospital, Detroit

☐ **Diabetes — Current Management and New Horizons**

PRESENTED BY: MSMS Section on Clinical Pharmacology and Therapeutics

This course will be presented for the physician managing the diabetic patient outside of the research setting. The content of the material will be pertinent for the family practitioner, internist, or pediatrician and will cover such subjects as: "What is Diabetes — Current Thinking and Classification," "The Management of Mature Onset Diabetes," "The Therapy of Major Diabetic Complications and Diabetic Coma," and a discussion on "New Horizons." Adequate time for questions and short consultations will be provided.

COURSE DIRECTOR: George L. Royer, Jr., MD, Manager of Medical Pharmacology, The Upjohn Company, Kalamazoo

PRESIDING: Doctor Royer

SPEAKERS/SUBJECTS:

Rebecca Norris, MD, The Upjohn Company, Kalamazoo
"Diabetes — What Is It?"

Karl E. Sussman, MD, Professor of Medicine, University of Colorado School of Medicine, Denver

"The Management of Mature Onset Diabetes"

Charles Shuman, MD, Professor of Medicine, Temple University School of Medicine, Philadelphia

"Complications and Diabetic Coma"

Stefan S. Fajans, MD, Director, Metabolism Research Unit, Division Endocrinology & Metabolism, University Hospital, Ann Arbor

"New Horizons"

☐ **Emergency Psychiatry: Theory and Practice**

PRESENTED BY: Michigan Psychiatric Society

All physicians encounter emergency problems in their practice that appear to be psychiatric. This course will cover differentiation of organic from functional disorders, assessments of suicide

intent, the mental health system and how to use it effectively, and why problems develop in the management of psychiatric emergencies.

COURSE DIRECTOR: Beverly J. Fauman, MD, Huntington Woods

PRESIDING: Doctor Fauman

SPEAKERS/SUBJECTS:

Beverly J. Fauman, MD, Assistant Professor of Psychiatry, University of Michigan Medical School; Director, Psychiatric Emergency, Henry Ford Hospital, Detroit

"Introduction of Psychiatric Emergencies"

"Some Problems in Emergency Psychiatry"

Michael Fauman, MD, Assistant Professor of Psychiatry, University of Michigan Medical School; Director of Psychiatric Consultation, Henry Ford Hospital, Detroit

"Differentiation of Organic from Functional Disorders"

"Use of Psychopharmacologic Agents"

Gail Barton, MD, Associate Professor of Psychiatry, University of Michigan Medical School

"The Mental Health System"

"Management of the Difficult Patient"

☐ **Physicians as Expert Witnesses: Continuing Medical Care**

PRESENTED BY: Michigan Medical Schools Council of Deans, Medical-Legal Project

Physician responsibility for patient care includes diagnosis, treatment and the sharing of information regarding each. The shared information allows patients to recover under insurance, workers' compensation, social security or civil action and no person is more qualified to provide this information than the treating physician. Participants should become more familiar with administrative and court decision-making systems. They should become more familiar with the "do's and don'ts" of expert testimony in administrative cases, personal injury cases generally and medical malpractice cases. This course will also attempt to familiarize physicians with the ethical, legal and financial aspects of being an expert witness.

CO-COURSE DIRECTORS: Daniel Bronstein, JD, Associate Professor of Psychiatry and Resource Development, Michigan State University College of Human Medicine; J. Douglas Peters, JD, Co-Project Director and Legal Director, Michigan Medical Schools Council of Deans, Medical-Legal Project, Ann Arbor, and Adjunct Assistant Professor, Wayne State University School of Medicine; David B. Youel, MD, practicing physician and Medical Director, Kalamazoo Professional Standards Review Council

PRESIDING: Daniel Bronstein, J. Douglas Peters and Doctor Youel

SPEAKERS/SUBJECTS:

J. Douglas Peters, JD

"Physicians as Expert Witnesses"

Daniel Bronstein, JD; J. Douglas Peters, JD and Keith S. Fineberg, JD, Project Director and Staff Attorney, Michigan Medical Schools Council of Deans, Medical-Legal Project, Ann Arbor

Question and Answer Session

Tuesday afternoon/continued

GROUP SESSIONS:

Ronald R. Gilbert, MD, of Charfoos, Christensen, Gilbert and Archer, PC, Detroit

Group A: "Expert Witnesses in Workers' Compensation and Social Security Disability Cases"

Daniel Bronstein, JD

Group B: "Expert Witnesses in General Negligence Cases"

Jared Buckley, JD, of Charfoos, Christensen, Gilbert and Archer, PC, Detroit

Group C: "Expert Witnesses in Medical Malpractice Cases"

Jared Buckley, JD, and **Donald Kroll, MD, PhD**, University of Michigan Medical School; Co-Project Director and Medical Director, Michigan Medical Schools Council of Deans, Medical-Legal Project, Ann Arbor

MOCK TRIAL — Cross Examination of Medical Expert Witness

☐ **Tonsillectomy and Adenoidectomy — Current Status**

PRESENTED BY: Michigan Otolaryngological Society

Tonsillectomy and adenoidectomy continue to be among the most frequently performed operations in the United States. Despite the performance of millions of these operations, hard data regarding indications for this procedure simply are not always

available. A thorough update on clinical and basic science research directed toward clarifying the indications and sequelae of adenotonsillectomy will be presented, including such considerations as adenotonsillectomy for recurrent sore throats, for nasal obstruction, for middle ear effusion, for recurrent otitis media, for dysphagia and for peritonsillar abscess. The internationally-recognized speakers are actively conducting clinical and basic science research to help clarify the indications and sequelae of adenotonsillectomy and are uniquely qualified to offer a review. Course participants will be invited to bring along questions regarding their own patients for discussion.

COURSE DIRECTOR: **Ronald S. Bogdasarian, MD**, Department of Otolaryngology, University of Michigan Medical School and Director of Otorhinolaryngology, Wayne County General Hospital, Westland

PRESIDING: **Doctor Bogdasarian**

SPEAKERS/SUBJECTS:

Charles D. Bluestone, MD, Professor of Otolaryngology, University of Pittsburgh School of Medicine; Director, Department of Otolaryngology, Children's Hospital of Pittsburgh

"Tonsillectomy and Adenoidectomy: 1980"

"Recent Advances in Otitis Media"

James A. McNamara, Jr., DDS, Association Research Scientist and Program Director, Experimental Craniofacial Research, Center for Human Growth and Development, University of Michigan Medical School; Assistant Professor, Department of Anatomy, University of Michigan Medical School

"Airway Problems in Facial Growth: What is the Relationship?"

Special two-day course, beginning Wednesday, Nov. 19

☐ **Advanced Cardiac Life Support (A 16-hour course to run all day Wednesday and Thursday)**

PRESENTED BY: Michigan Chapter, American College of Emergency Physicians

This course is a nationally recognized training and certification program. It consists of lecture material and new concepts in training and testing for the practical skills of Advanced Cardiac Life Support. Lectures will deal with adjuncts for airway and ventilation, circulation, monitoring and dysrhythmia recognition, defibrillation and synchronized cardioversion and establishment of IV's. The eight stations used to train the participants in ACLS skills are: basic life support (1 and 2 person CPR), adjuncts for airway, endotracheal intubation, esophageal intubation, placement of central venous catheters, ventricular fibrillation and defibrillation, recognition of dysrhythmias and drug therapy for dysrhythmias.

COURSE DIRECTOR: **Craig E. Downs, DO**, Director of Emergency Medical Services, Lansing General Hospital

COORDINATOR: **Shirley A. Bader, RN**, Lansing General Hospital

FACULTY:

Robert Aranorian, DO, Pontiac Osteopathic Hospital, Pontiac; **Paul Berlin**, paramedic, Midland Hospital, Midland; **Karren Foster, LPN**, Bay Medical Center, Bay City; **James Johnson, MD**, Northern Professional Emergency Physicians, Traverse City; **Michael Levine, MD**, Emergency Department, Mt. Carmel Mercy Hospital, Detroit; **Neal Little, MD**, Emergency Department, St. Joseph Mercy Hospital, Ann Arbor; **Kathi Mostek, RN**, Bay Medical Center, Bay City; **Richard M. Nowak, MD**, Henry Ford Hospital, Detroit; **Paul Pomeroy, MD**, Dearborn Heights; **Margo Roedel, RN**, Bay Medical Center, Bay City; **Sandy Shutt, RN**, Bay Medical Center, Bay City; **Daniel R. Sorenson, MD**, Emergency Medical Services, Midland Hospital, Midland; **John Wolford**, paramedic, Emergency Medical Services, Detroit; **Peter J. Zenti, MD**, Emergency Department, Marquette General Hospital, Marquette

Courses Wednesday morning, Nov. 19

All courses run from 8:30 to noon with half-hour break

☐ **Clinical Toxicology in the Emergency Department**

PRESENTED BY: Michigan Chapter, American College of Emergency Physicians

This course will provide a general approach to recognition, stabilization and management of the poisoned patient. Any physician (emergency, general practitioner, internist, pediatrician, and psychiatrist) will benefit from an in-depth review plus the new and changing concepts in the field of clinical toxicology.

COURSE DIRECTOR: Michael R. Clark, MD, Lansing

PRESIDING: Doctor Clark

SPEAKERS/SUBJECTS:

Michael R. Clark, MD, Director, Department of Emergency Medicine, E. W. Sparrow Hospital, Lansing; Program Director, Emergency Medicine Residency — MSU Affiliated Hospitals; Assistant Clinical Professor, Michigan State University College of Human Medicine

"Clinical Toxicology in the Emergency Department"

☐ **Colon Polyp — Cancer Sequence: A Rational Approach**

PRESENTED BY: Michigan Society for Gastrointestinal Endoscopy

Over 100,000 persons in the United States will develop colon carcinoma in 1980 and over 50,000 will die. The aim of this course is to provide a rational approach to the management and detection of colon polyps in the asymptomatic and symptomatic patient. Who should be followed closely, how often should patients be screened and what polyps should be removed by colonoscopy, will be presented. The role of flexible sigmoidoscopy, colonoscopy, and electrosurgical polypectomy will be discussed and video tapes will be shown of colonoscopic polypectomy. The sequence of colon carcinoma developing from an adenomatous polyp will be reviewed in detail.

COURSE DIRECTOR: John P. Papp, MD, Associate Clinical Professor of Medicine, Michigan State University College of Human Medicine

PRESIDING: Doctor Papp

SPEAKERS/SUBJECTS:

Gustav A. Uhlich, MD, Chief of Gastrointestinal Service, Burns Clinic, Petoskey

"Screening Methods for Detection of Colon Carcinoma"

Edmund M. Barbour, MD, Associate Clinical Professor of Medicine, Wayne State University School of Medicine

"A Rational Approach for Cancer Surveillance"

Ramon R. Joseph, MD, Professor of Internal Medicine, University of Michigan Medical School

"The Value of X-Ray versus Colonoscopy in Detection of Colon Polyps and Cancer"

Eugene A. Gelzayd, MD, Associate Clinical Professor of Medicine, Wayne State University School of Medicine

"The Role of Flexible Sigmoidoscopy in Cancer Detection and Surveillance"

Jerome D. Waye, MD, President, American Society for Gastrointestinal Endoscopy, New York, NY

"The Cancer-Polyp Sequence"

"Electrosurgical Colonic Polypectomy"

"How to Manage Small Colonic Polyps Less Than 5mm"

☐ **Common Orthopaedic Problems**

PRESENTED BY: Michigan Orthopaedic Society

This course will present updated information on the diagnosis and treatment of common musculo-skeletal disorders. The course will be aimed at primary care physicians, as well as orthopaedic specialists and will present information on evaluation and treatment of some common disorders such as back problems, upper and lower extremity disorders, including some discussion of chronic pain conditions.

COURSE DIRECTOR: Christopher L. Lee, MD, Instructor of Orthopaedic Surgery, Wayne State University School of Medicine

PRESIDING: Doctor Lee

SPEAKERS/SUBJECTS:

Arthur Manoli, MD, Assistant Professor, Department of Orthopaedics, Wayne State University School of Medicine

"Common Back Disorders"

J. R. Ryan, MD, Associate Professor, Department of Orthopaedics, Wayne State University School of Medicine

"Disorders of the Lower Extremity"

Gino G. Saliccioli, MD, Associate Professor, Orthopaedic Surgery, Wayne State University School of Medicine

"Disorders of the Upper Extremity"

☐ **Dermatology for the Non-Dermatologist**

PRESENTED BY: Michigan Dermatological Society

The course will present a brief review of the most common dermatologic conditions which the non-dermatologist is likely to encounter in his office. Subjects will include 1) the most common dermatoses; 2) dermatitis; 3) the most common pigment disorders; 4) pediatric dermatology; and 5) the cutaneous manifestations of connective tissue diseases.

COURSE DIRECTOR: Margaret C. Douglass, MD, Detroit

PRESIDING: Doctor Douglass

SPEAKERS/SUBJECTS:

D'Anne Fachnie, MD, staff physician, Department of Dermatology, Henry Ford Hospital, Detroit

"The Most Common Dermatoses"

Joseph W. McGoe, MD, staff physician, Department of Dermatology, Henry Ford Hospital, Detroit

"Dermatitis"

Alejandro Morales, MD, staff physician, Department of Dermatology, Henry Ford Hospital, Detroit

"The Most Common Pigment Disorders of The Skin"

Margaret C. Douglass, MD, staff physician, Department of Dermatology, Henry Ford Hospital, Detroit

"The Most Common Pediatric Dermatoses"

Wednesday morning/continued

Thomas K. Burnham, MD, staff physician, Department of Dermatology, Henry Ford Hospital, Detroit
“Cutaneous Manifestations of the Connective Tissue Diseases”

☐ **Effectiveness of Treating Hypertensive Patients: Newer Data**

PRESENTED BY: Department of Medicine, Wayne State University School of Medicine

This course should equip the participant with the latest data on the rationale for treatment of high blood pressure. It will review pathophysiology of hypertension and present physicians with the newest information on nutritional management of this disease.

COURSE DIRECTOR: Charles P. Lucas, MD, Detroit

PRESIDING: Doctor Lucas

SPEAKERS:

James A. Thomas, MD, Associate Professor of Pharmacology, Wayne State University School of Medicine
Elijah Saunders, MD, instructor in cardiology and medicine, University of Maryland School of Medicine; Chief of Cardiology, Provident Hospital, Baltimore
Charles P. Lucas, MD, Professor of Medicine, Wayne State University School of Medicine

This course is supported in part by a financial grant from Boehringer-Ingelheim Ltd.

☐ **Genetic Issues in General Practice**

PRESENTED BY: Department of Pediatrics and Human Development, Michigan State University College of Human Medicine

This course, which is designed for primary care providers, will present information on basic and clinical genetic issues. Speakers will discuss chromosomal abnormalities, the importance of family history in genetic evaluations, genetic and environmental interaction in specific conditions and also genetic diagnosis during pregnancy. There will be ample time for questions and answers and participants are encouraged to bring case histories from their own practices for discussion.

COURSE DIRECTOR: Saroj Kapur, MD, East Lansing

PRESIDING: Doctor Kapur

SPEAKERS/SUBJECTS:

James V. Higgins, PhD, Professor, Pediatrics/Human Development, Michigan State University College of Human Medicine
“Basis of Chromosomal Abnormalities Etiology and Recurrence Risk”
Donald F. Waterman, MD, Professor, Pediatrics/Human Development, Michigan State University College of Human Medicine
“Importance of Family History in Genetic Evaluation – Pedigree Analysis”
Saroj Kapur, MD, Associate Professor, Pediatrics/Human Development, Michigan State University College of Human Medicine

“Evaluation of a Dysmorphic Child/Genetic and Environmental Interaction”

Gerald B. Holzman, MD, Professor, Department of Obstetrics and Gynecology, Michigan State University College of Human Medicine

“Genetic Diagnosis in 2nd Trimester of Pregnancy”

☐ **Health Planning: Impact on the Physician and Patient Care**

PRESENTED BY: Michigan Department of Public Health and MSMS Physician HSA/Support Center

This course will present the background of health planning at the federal and state level. Fundamentals will be described, as well as the role each segment of the health planning structure plays. This will be followed by specifics on the physicians' responsibilities and concludes with the theoretical and actual impact on the patient. Upon completion of this course, a physician should be able to determine what role he/she could and should play in the health planning process.

COURSE DIRECTOR: Maurice S. Reizen, MD, Director, Michigan Department of Public Health, Lansing; Member of Statewide Health Coordinating Council

PRESIDING: Doctor Reizen

SPEAKERS/SUBJECTS:

Dennis M. Paradis, MPH, Coordinator of Health Planning, Michigan State Medical Society, East Lansing
“HSA: A Challenge to Medicine”
Kenneth J. Ray, MD, Detroit, Chairman, MSMS Steering Committee on Health Planning
“Planning Requirements”
Hermann A. Ziel, Jr., MD, Chief, Bureau of Health Care Administration, Michigan Department of Public Health, Lansing
“Regulatory Aspects of Planning”
James D. Fryfogle, MD, Southfield, Chairman, Seven-County Health Planning Advisory Committee
“Physicians' Role in Planning, Certificate of Need and Debedding”
Reverend Terry L. Daly, Muskegon, Chairman, Statewide Health Coordinating Council
“Consumers' Role in Planning, Certificate of Need and Debedding”
Robert J. Toteff, MD, Saginaw, Vice-Chairman, Statewide Health Coordinating Council; Member of MSMS Steering Committee on Health Planning
“Impact of Planning on Patient Care”

☐ **Psycho-Pharmacology: Anti-Depressants**

PRESENTED BY: Michigan Psychiatric Society

This course will be directed to primary care physicians and will emphasize the following: a) How does one recognize depression (and mania) in everyday clinical practice? b) What types of depression are amenable to pharmacologic treatment? c) What pharmacologic agents are used to treat depression and mania? d) How do you use these agents? e) What are the benefits and the adverse reactions of these agents? f) What are the drug interactions that one must keep in mind when using these agents?

Wednesday morning/continued

CO-COURSE DIRECTORS: **Kenneth R. Silk, MD**, Clinical Assistant Professor of Psychiatry, University of Michigan Medical School, and **Linda J. Logsdon, MD**, Southfield, Practicing Psychiatrist and Chairperson for Program and Women's Committee of MPS

PRESIDING: Doctors **Silk and Logsdon**

SPEAKERS/SUBJECTS:

Michael P. Feinberg, MD, PhD, Assistant Professor of Psychiatry, Clinical Studies Unit, University of Michigan Medical School

"Phenomenology of Depression: Recognition of Depression in Everyday Clinical Practice"

Samuel Gershon, MD, Director, Lafayette Clinic; Professor and Chairman, Department of Psychiatry, Wayne State University School of Medicine

"Psycho-Pharmacology of the Lithium Ion"

Steven Lipper, MD, PhD, Associate Professor of Psychiatry, University of Michigan Medical School; Staff Psychiatrist, Ann Arbor V.A. Medical Center

"The Use of Tricyclic Anti-Depressants and the MAO Inhibitors"

☐ **Skin Cancer — Including Malignant Melanomas**

PRESENTED BY: Michigan Academy of Plastic Surgeons

This course is designed for primary care physicians, dermatologists and plastic surgeons. The first half of the course will concern itself with the clinical recognition of the common skin malignancies and methods of treatment. A radiotherapist, a dermatologist and a plastic surgeon will outline the indications, contraindications and results of their particular treatment method. The second half is devoted to discussion of melanomas: clinical recognition, significance of microinvasion, staging of the disease, methods of treatment, follow up and results. Other lesser known but important facts about a disease whose incidence is rapidly rising in this country will be discussed. A question and answer period will follow each half of this course.

COURSE DIRECTOR: **Errikos Constant, MD**, Lansing

PRESIDING: **M. Haskell Newman, MD**, Assistant Professor, Plastic and Reconstructive Surgery, University of Michigan Medical School

SPEAKERS/SUBJECTS:

Ralph R. Edminster, MD, Dermatopathologist, Edward W. Sparrow Hospital, Lansing, Clinical Associate Professor of Pathology, Michigan State University College of Human Medicine

"The Clinical and Histologic Varieties of Basal and Squamous Cell Carcinomas — Including the Basal Cell Mevoid Syndrome and Keratoacanthomas"

J. Howard Binns, MD, Clinical Associate Professor of Surgery and Director, Wayne State University Affiliated Program in Plastic Surgery, Detroit

"Skin Cancer: How I Treat It — Surgery"

J. Clyde Spencer, MD, Chairman, Department of Radiology, Edward W. Sparrow Hospital, Lansing; Associate Clinical Professor, Michigan State University College of Human Medicine

"Skin Cancer: How I Treat It — Radiotherapy"

Neil Swanson, MD, Instructor of Dermatology, University of Michigan Medical School

"Skin Cancer: How I Treat It — Chemosurgery"

Martin C. Robson, MD, Professor of Surgery, Chief, Section of Plastic Surgery, University of Chicago Medical School

"Treatment of Malignant Melanomas"

Errikos Constant, MD, Chief, Section of Plastic Surgery, Edward W. Sparrow Hospital, Lansing; Clinical Associate Professor of Surgery, Michigan State University College of Human Medicine

"Melanomas: Lesser Known but Vital Facts (giant nevi, the B-K mole syndrome, multiple melanomas, melanomas in blacks, children, and in pregnancy, regressing melanomas)"

☐ **Thoracic Trauma: Problems in Diagnosis, Early Management and Disposition**

PRESENTED BY: Division of Trauma Surgery and Critical Care Medicine, Henry Ford Hospital, Detroit

The educational objective of this CME course is to familiarize family physicians, who have any responsibility for the care of trauma patients with current concepts in the recognition, early management, and disposition of patients who have sustained blunt or penetrating injuries of the chest. Didactic material will be presented in a series of five lectures followed by questions and answers. Knowledge and performance improvement will be assessed by a pre-course objective examination and post-course examination utilizing actual case histories from which the questions utilized in each examination were derived.

COURSE DIRECTOR: **Dennis P. Horan, MD**, Detroit

PRESIDING: Doctor **Horan**

SPEAKERS/SUBJECTS:

Dennis P. Horan, MD, Head, Division of Trauma Surgery and Critical Care Medicine, Henry Ford Hospital, Detroit

"Penetrating Injuries to the Heart and Great Vessels"

David C. Green, MD, Division of Thoracic and Cardiovascular Surgery, University of Maryland Hospital, Baltimore

"Deceleration Injuries to the Great Vessels"

Joseph W. Lewis, MD, Division of Thoracic and Cardiovascular Surgery, Henry Ford Hospital, Detroit

"Common Problems in the Management of Thoracic Trauma"

Ralph A. Babcock, MD, Section of Critical Care Medicine, Henry Ford Hospital, Detroit

"Early Recognition of the Acute Respiratory Distress Syndrome"

James C. Gruenberg, MD, Department of Surgery, Henry Ford Hospital, Detroit

"The Use of Peritoneal Lavage in the Recognition of Thoracic Abdominal Injuries"

Courses Wednesday afternoon, Nov. 19

All courses run from 1:30 to 5 p.m. with half-hour breaks

☐ **Bronchial Asthma in Children and Adults**

PRESENTED BY: Michigan Allergy Society

This course will provide practical information about the pathophysiology, clinical and laboratory appraisal, and management of bronchial asthma in children and adults. It is designed to be of greatest value to primary care physicians. Pathophysiology will be reviewed in order to present the different modalities of therapy in the logical and rational view. Specific details of management will include appropriate drug therapy for acute and chronic asthma, suggestions for environmental control, and the role of immunotherapy. Format will be lecture-slide presentation followed by an open panel discussion.

COURSE DIRECTOR: Cory E. Cookingham, MD, President, Michigan Allergy Society, Flint

PRESIDING: Doctor Cookingham

SPEAKERS/SUBJECTS:

Lawrence C. Sweet, MD, Chairman, Allergy Division, William Beaumont Hospital, Royal Oak

"Pathophysiology of Asthma"

John A. Anderson, MD, Head, Division of Allergy and Clinical Immunology, Henry Ford Hospital, Detroit

"Clinical Appraisal of Asthma"

Thomas Van Metre, Jr., MD, Associate Professor and Physician-in-Charge, Allergy Clinic, Johns Hopkins Hospital, Baltimore

"Therapy of Asthma"

☐ **Current Approaches in Diagnosis and Management of Cancer of the Lung**

PRESENTED BY: Department of Medicine, Michigan State University College of Human Medicine

This course will provide primary physicians with a review of current advances in the diagnosis and treatment of cancer of the lung. Upon completion of this course the primary physician will know what imaging techniques are useful in lung cancer and the indications for surgical and radiotherapeutic intervention. Advantages and limitations of chemotherapy and immunotherapy will be presented as well as the possible position of interferon in future therapeutic programs of lung cancer.

COURSE DIRECTOR: Leif G. Suhrland, MD, Professor, Department of Medicine, Michigan State University College of Human Medicine

PRESIDING: Doctor Suhrland

SPEAKERS/SUBJECTS:

Kay Vydareny, MD, Assistant Professor, Department of Radiology, Michigan State University College of Human Medicine

"Imaging Techniques in Diagnosis and Staging of Lung Cancer"

J. Clyde Spencer, MD, Associate Clinical Professor, Department of Radiology, Michigan State University College of Human

Medicine; Chairman, Department of Radiology and Director of Radiation Oncology, Edward W. Sparrow Hospital, Lansing

"Current Indications for Radiotherapy in Lung Cancer"

D. Bonta Hiscoe, MD, Clinical Professor, Department of Surgery, Michigan State University College of Human Medicine; Medical Director, Health Central, Lansing

"Surgery in the Diagnosis and Management of Lung Cancer"

David A. Decker, MD, Assistant Professor, Department of Medicine, Michigan State University College of Human Medicine

"Chemotherapy of Lung Cancer – An Update"

Mikolay V. Dimitrov, MD, Professor, Department of Medicine, Michigan State University College of Human Medicine

"Chemo-Immunotherapy and Interferon in Lung Cancer"

☐ **Current Concepts in the Management of Electrolyte Disorders**

PRESENTED BY: Division of Nephrology, University of Michigan Medical School

This course will deal with current concepts in the pathophysiology, diagnosis and management of hyperkalemia, hypophosphatemia and hyponatremia. The format will include three 45-minute lectures with 15 minutes for questions following each presentation. This course will update the audience in current concepts regarding the management of these clinical problems.

COURSE DIRECTOR: Richard L. Tannen, MD, Ann Arbor

PRESIDING: Doctor Tannen

SPEAKERS/SUBJECTS:

Richard L. Tannen, MD, Professor of Medicine and Director, Nephrology Division, University of Michigan Medical School

"Hyperkalemia"

Y. Kai Lau, MD, Assistant Professor of Medicine, University of Michigan Medical School

"Hypophosphatemia"

H. David Humes, MD, Assistant Professor of Medicine, University of Michigan Medical School

"Hyponatremia"

☐ **Diagnosis and Curative Management of Breast Cancer**

PRESENTED BY: Hutzel Hospital Surgical Unit, Wayne State University School of Medicine

This course will provide practical information on how to recognize and manage the woman with a suspicious lesion of the breast. Emphasis will be placed on how to decide what to do to cure breast cancer. Those strategies which have been demonstrated to result in the cure of breast cancer will be described in enough detail so that the participants will be able to apply this information in their practices. Opportunities will be provided for discussion by participants with members of the faculty.

Wednesday afternoon/continued

COURSE DIRECTOR: Jerry C. Rosenberg, MD, PhD, Hutzel Hospital Surgical Unit, Wayne State University School of Medicine

PRESIDING: Doctor Rosenberg

SPEAKERS/SUBJECTS:

Debra A. Schmidt, RN, Chief Nurse Examiner, Breast Cancer Detection/Education Center, Oakland County Division of Health, Southfield

"Proper Examination of the Breast by the Physician and Patient"

Kenneth L. Krabbenhoft, MD, Professor and Chairman, Department of Radiology, Wayne State University School of Medicine

"Significance of the Mammogram"

John P. Minton, MD, Professor of Surgery and Clinical Oncology, Ohio State University College of Medicine, Columbus

"Risk Factors and Surgical Management of Breast Lesions"

Michael Brennan, MD, Professor of Oncology, Wayne State University School of Medicine; President, Michigan Cancer Foundation

"Adjuvant Therapy for Cure of Breast Cancer"

Horst Seydel, MD, Professor of Radiation Oncology, Wayne State University School of Medicine

"Radiation Therapy as the Primary Modality for the Treatment of Breast Cancer"

☐ **Diagnosis and Treatment of Colon and Rectal Disease**

PRESENTED BY: Michigan Society of Colon and Rectal Surgeons

This portion of the scientific program is designed to acquaint the clinician with some of the common problems frequently seen in the offices of colon and rectal surgeons. Through the sections on diarrhea, irritable bowel syndrome and office proctology and the discussion of symptomatic diverticulosis and diverticulitis, physicians should be better informed on the treatment of these complications as they arise.

COURSE DIRECTOR: Robert E. McKnight, MD, practicing colon and rectal surgeon, Providence Hospital, Southfield; President, Michigan Society of Colon and Rectal Surgeons

PRESIDING: Doctor McKnight

SPEAKERS/SUBJECTS:

Freddy Sosa, MD Clinical Instructor of Gastroenterology, Wayne State University School of Medicine; Department of Gastroenterology, Providence Hospital, Southfield

"Diarrhea – Causes and Treatment"

Lawrence Stawick, MD, Clinical Instructor of Gastroenterology, Wayne State University School of Medicine; Department of Gastroenterology, Providence Hospital, Southfield

"The Irritable Bowel Syndrome"

William Beauregard, MD, Chief, Colon and Rectal Surgery, William Beaumont Hospital, Royal Oak

"What's New in Office Proctology"

Frank Weakley, MD, Chairman, Department of Colon and Rectal Surgery, The Cleveland Clinic, Cleveland

"Surgical Treatment of Diverticulosis-Diverticulitis at Cleveland Clinic, Cleveland, Ohio"

Panel Discussion of "Diverticulosis and Diverticulitis": **Thomas Fox, MD**, Chief, Colon and Rectal Surgery, Henry Ford Hospital, Detroit; **W. Patrick Mazier, MD**, Associate Clinical Professor of Surgery, Michigan State University College of Human Medicine and Staff, Ferguson-Droste-Ferguson Clinic, Grand Rapids; **Doctors Sosa, Stawick, Weakley**

☐ **Everything You Always Wanted to Know About Local Anesthetics**

PRESENTED BY: Michigan Society of Anesthesiologists

This course is intended for practitioners in all fields of medicine who use local anesthesia. Based upon a presentation of the clinical pharmacology and physiology of local anesthetics, the participant will then learn which agent and concentration is best suited for their needs. Special consideration will be given to handling the allergic patient and treatment of toxic reactions.

COURSE DIRECTOR: Gaylord D. Alexander, MD, Attending Anesthesiologist, Sinai Hospital of Detroit and Associate Professor of Anesthesiology, Wayne State University School of Medicine

PRESIDING: Doctor Alexander

SPEAKERS/SUBJECTS:

Stuart L. Bloom, DO, attending anesthesiologist, Providence Hospital, Southfield

"Which Local Anesthetic Should I Use – Pharmacologic Principles"

Gianfranco DalSanto, MD, Professor of Anesthesiology, Wayne State University School of Medicine

"Kinetics of Distribution of Local Anesthetics"

Seymour Adelson, MD, Clinical Assistant Professor of Medicine, Wayne State University School of Medicine; Co-Chairman, Allergy Section, Sinai Hospital of Detroit

"How to Handle the Patient who is Allergic to Local Anesthetics"

Milford Wenokur, MD, Assistant Professor of Anesthesiology, Wayne State University School of Medicine

"Topical Anesthetics and Their Use"

Eli M. Brown, MD, Professor and Chairman, Department of Anesthesiology, Wayne State University School of Medicine

"Intravenous Regional Anesthesia"

A. M. DeRosayro, MD, Assistant Professor of Anesthesiology and Chief, Obstetrical Anesthesia, University of Michigan Medical School

"Kinetics and Toxicity of Local Anesthetics in the Fetus"

Richard Horsch, MD, Anesthesiologist, St. Mary's Hospital, Livonia; President, Michigan Society of Anesthesiologists

"Toxic Reactions – Prevention and Treatment"

☐ **Injuries to the Genito-Urinary Tract**

PRESENTED BY: Michigan Branch, American Urological Association

This course will teach evaluation and management of trauma to the genito-urinary organs by means of lectures and also case presentations. The course will include discussion of the similarities and differences in the management of trauma in children and adults.

COURSE DIRECTOR: Gerald F. Conway, MD, Royal Oak, Secretary, Michigan Branch, American Urological Association

PRESIDING: Doctor Conway

SPEAKERS/SUBJECTS:

James M. Pierce, MD, Professor and Chairman of Urology, Wayne State University School of Medicine

"Trauma to the Bladder and Urethra"

Joseph C. Cerny, MD, Professor and Chairman of Urology, Henry Ford Hospital, Detroit

"Trauma to the Kidneys and Ureters"

R. Lawrence Kroovand, MD, Professor of Urology, Wayne State University School of Medicine; Department of Urology, Children's Hospital of Michigan, Detroit

"Trauma in the Pediatric Age-Group"

Richard P. Dorr, MD, Clinical Associate Professor of Surgery, University of Michigan Medical School

"Iatrogenic Trauma to the Urinary Tract"

William G. Guerriero, MD, Professor of Urology, Baylor College of Medicine, Houston, Texas

"Urologic Trauma: An Overview"

☐ Management of Difficult Soft Tissue Wounds

PRESENTED BY: Michigan Academy of Plastic Surgeons

This advanced course will discuss some of the difficult soft tissue wounds encountered by primary care and emergency room physicians and surgical specialists (orthopaedic, general, plastic). The immediate evaluation of these wounds as well as the most appropriate methods for their repair will be discussed. Common misconceptions about the nature of these wounds and pitfalls in management will be emphasized. The material will be presented in 20-25 minute lectures, with ample time for questions from the audience.

COURSE DIRECTOR: Errikos Constant, MD, Lansing

PRESIDING: Doctor Constant

SPEAKERS/SUBJECTS:

Martin C. Robson, MD, Professor of Surgery, Chief, Section of Plastic Surgery, University of Chicago Medical School

"Managing the Burn Wound"

Alexander P. Kelly, Jr., MD, Chief, Department of Plastic Surgery, Henry Ford Hospital, Detroit; Clinical Associate Professor of Surgery, University of Michigan Medical School

"The Electrical Burn Wound (high and low voltage)"

Doctor Robson

"The Leg Ulcer: Etiology, Bacteriology and Management"

Louis Argenta, MD, Instructor, Department of Surgery, Section of Plastic Surgery, University of Michigan Medical School

"Radiation Injury: Recognition and Treatment"

M. Haskell Newman, MD, Assistant Professor, Plastic and Reconstructive Surgery, University of Michigan Medical School

"Difficult Head and Neck Wounds"

☐ Psycho-Pharmacology: Anti-Anxiety Agents

PRESENTED BY: Michigan Psychiatric Society

This course will explore for primary care physicians the diagnosis and treatment of anxiety and insomnia. a) How does one diagnose anxiety? b) What drugs are used to treat anxiety? c) Why benzodiazepines? d) What are the differences between benzodiazepines? e) What are the side-effects and kinetics of these drugs? f) How does one use the Beta Blockers in the treatment of anxiety? g) How does one treat panic attacks? h) How does one diagnose and treat insomnia? i) What are the differences among the sleeping medications?

CO-COURSE DIRECTORS: Kenneth R. Silk, MD, Clinical Assistant Professor of Psychiatry, University of Michigan Medical School, and Linda J. Logsdon, MD, Southfield, Practicing Psychiatrist and Chairperson for Program and Women's Committee of MPS

PRESIDING: Doctors Silk and Logsdon

SPEAKERS/SUBJECTS:

Richard Shader, MD, Professor and Chairman, Department of Psychiatry, Tufts University School of Medicine; Boston; Psychiatrist-in-Chief, New England Medical Center Hospital, Boston

"The Diagnosis and Treatment of Anxiety"

Lowell I. Goodman, MD, Associate Director, Clinical Therapeutics — CNS, Clinical Research Department, Werner-Lambert-Parke Davis Co.; Clinical Assistant Professor of Psychiatry, University of Michigan Medical School

"The Diagnosis and Treatment of Insomnia"

☐ Update on Cutaneous Mycology and Bacteriology — 1980

PRESENTED BY: Michigan Dermatological Society

The course will present an update of cutaneous bacteriology and mycology, emphasizing newer aspects of which the practitioner may not be aware. Subjects will include pyodermas, new and unusual fungal infections of the skin, and unusual systemic and opportunistic fungal infections. The emphasis will be on clinical manifestations.

COURSE DIRECTOR: Margaret C. Douglass, MD, Staff Physician, Department of Dermatology, Henry Ford Hospital, Detroit

PRESIDING: Doctor Douglass

SPEAKERS/SUBJECTS:

James J. Leyden, MD, Department of Dermatology, University of Pennsylvania School of Medicine, Philadelphia

"The Clinical Microbiological Correlations of Primary and Secondary Pyoderms"

John Rippon, PhD, Department of Dermatology, University of Chicago, The Pritzker School of Medicine

"New and Unusual Fungal Infections of the Skin — A Physiology of Recurrent Tinea Corporis, B) Emergence of Protothecosis as a Common Infectious Disease, C) Trichosporin Beigelii as a Systemic Opportunist"

Alvin L. Rogers, Associate Professor, Department of Botany and Plant Pathology, Michigan State University

"Fungal Exoantigens and their Applications in Medical Mycology"

"Sporothrix, Schenckii from Animal to Human (a case of Sporotrichosis)"

Courses Thursday morning, Nov. 20

All courses run from 8:30 to noon with half-hour break

□ Chronic Head Pain

PRESENTED BY: Sinai Hospital of Detroit and Departments of Otorhinolaryngology, University of Michigan Medical School, and Wayne State University School of Medicine

This course will take a multidisciplinary approach to the diagnosis and treatment of headaches. The course will be aimed at primary care physicians and will include discussions of treatment involving the areas of neurology, otolaryngology, physical therapy, oral surgery, psychiatry, anesthesiology, allergy and ophthalmology.

CO-COURSE DIRECTORS: Eugene Rontal, MD, and Michael Rontal, MD, Southfield

PRESIDING: Doctor Eugene Rontal

SPEAKERS/SUBJECTS:

Eugene Rontal, MD, and Michael Rontal, MD, Sinai Hospital of Detroit; Departments of Otorhinolaryngology, University of Michigan Medical School and Wayne State University School of Medicine

"Sinus Causes of Headaches"

Milford Wenokur, MD, Assistant Professor of Anesthesiology, Wayne State University School of Medicine

"Pain Treatment with Nerve-Block"

John Helfrick, DDS, Chairman, Department of Dental and Oral Surgery, Sinai Hospital of Detroit

"Dental Causes of Headaches"

Ronald E. Trunsky, MD, Associate Professor of Psychiatry, Wayne State University School of Medicine

"Psychiatric Causes of Headaches"

William Leutcher, MD, Department of Neurology, Sinai Hospital of Detroit

"Neurological Causes of Headaches"

Hugh Beckman, MD, Clinical Associate Professor of Ophthalmology, Wayne State University School of Medicine

"Ophthalmological Causes of Headaches"

Maurice Ellenberg, MD, Rehabilitative Medicine, Sinai Hospital of Detroit

"Physical Therapy Treatment of Headaches"

William Floyd, MD, Department of Obstetrics and Gynecology, Sinai Hospital of Detroit

"Obstetrical & Gynecological Causes of Headaches"

□ Common Ophthalmic Problems

PRESENTED BY: Michigan Ophthalmological Society

This course will deal with ophthalmic problems likely to be seen in practitioners' offices and it will include an interesting contrast between the "wet eye" and the "dry eye." A highlight

of this course will be a short clinic on the use of the direct and indirect ophthalmoscope with time for the audience to practice, coupled with an explanation of retinal diseases that use of the ophthalmoscope might detect. Audience participation will be encouraged with time for questions and answers.

COURSE DIRECTOR: Frederick W. Bryant, MD, Royal Oak

PRESIDING: Doctor Bryant

SPEAKERS/SUBJECTS:

David Barsky, MD, President, Michigan Ophthalmological Society and Ocular Pathologist, Eye Clinic of Wyandotte; Department of Pathology, William Beaumont Hospital, Royal Oak

"The Wet Eye"

Carole West, MD, corneal specialist, Detroit Institute of Ophthalmology, Detroit

"The Dry Eye"

Frederick W. Bryant, MD, practicing ophthalmologist, William Beaumont Hospital, Royal Oak

"Wet Clinic for Direct and Indirect Ophthalmoscopy"

(including demonstration and practice)

Raymond R. Margherio, MD, Chief, Department of Ophthalmology, Michigan State University College of Human Medicine and William Beaumont Hospital, Royal Oak

"What You Didn't Know about Retinal Vascular Disease and Were Afraid to Ask"

□ Elective Surgical Procedures in the Elderly

PRESENTED BY: Department of Surgery, Henry Ford Hospital, Detroit

The course is intended to put into focus the issue of elective surgical procedures on elderly patients and will be directed at general surgeons, specialty surgeons, family practitioners and internists. Presentations on elective surgical procedures for groin hernias, peripheral vascular occlusive disease, colon diseases, cholelithiasis and cholecystitis will be used as clinical target subjects. The expansion of the geriatric population and the increasing demand for surgical treatment of long-existing surgical problems make the subject matter timely and pertinent to practice aspects of surgeons and non-surgeons alike.

COURSE DIRECTOR: Angelos K. Kambouris, MD, Detroit

PRESIDING: Doctor Kambouris

SPEAKERS/SUBJECTS:

Joseph L. Ponka, MD, Clinical Professor of Surgery, University of Michigan Medical School; Senior Surgeon, Henry Ford Hospital, Detroit

"Hernia Repairs in the Elderly"

Thursday morning/continued

Angelos A. Kambouris, MD, Clinical Associate Professor of Surgery, Wayne State University School of Medicine; Head, Division IV, Department of Surgery, Henry Ford Hospital, Detroit
"Biliary Operations in the Elderly"

D. Emerick Szilagyi, MD, Clinical Professor of Surgery, University of Michigan Medical School; Consultant, Department of Surgery, Henry Ford Hospital, Detroit

"Peripheral Vascular Surgery in the Aged Patient"

Thomas A. Fox, MD, Clinical Assistant Professor of Surgery, University of Michigan Medical School; Head, Division of Colo-Rectal Surgery, Henry Ford Hospital, Detroit

"Colon Resections in the Elderly Patient"

☐ **Management of Abortion — Current Aspects**

PRESENTED BY: Michigan Psychiatric Society

This course will consist of a panel presenting four views of abortion — a zoom lens shot through history, exploring myth, medicine, morality, mores and law. A capsule background of these considerations, suggestions for modification, and some tentative projective probes into the near future will be offered. No prejudicial stand will be taken and the faculty invites audience participation and criticisms. The course is intended for all physicians, and will present current information on the management of abortion in an objective manner.

COURSE DIRECTOR: Ruth S. Day, MD, Grosse Pointe Shores

PRESIDING: Doctor Day

SPEAKERS/SUBJECTS:

Ruth S. Day, MD, Senior Attending Psychiatrist, South Macomb Detroit Memorial Hospitals; Psychiatric Consultant, Clinic for Child Study, Probate Court, Juvenile Division, Wayne County

"The Plight of Women re Abortion — Their Guilt and Immunity"

Dorothy Bloch, MA, Associate Professor, Child Guidance, Long Island University, New York; Dean, Training Institute of National Psychological Association for Psychoanalysis, New York; Author of "So the Witch Won't Eat Me"

Albert Hodari, MD, Medical Director, Obstetrics and Gynecology, Detroit Macomb Hospital Association, and St. Joseph Mercy Hospital; Assistant Director of Medical Education, Detroit Macomb Hospital Association

"A Straight View of the Realities of Abortion Today"

Gladys Barsemian, Judge of Probate Juvenile Division, Detroit
"Abortion and the Law at this Time"

☐ **Non-Invasive Diagnosis of Peripheral Vascular Disease**

PRESENTED BY: Second Surgical Division (Peripheral Vascular), Henry Ford Hospital, Detroit

The program is designed to acquaint physicians with the application of non-invasive techniques for the diagnosis of peripheral vascular disease. Speakers will discuss the underlying physiological principles and describe the use and limitation of a variety of diagnostic approaches. The physician, on completion of this course, should be able to logically plan a non-invasive evaluation of cerebrovascular, venous and peripheral arterial disease.

COURSE DIRECTOR: Joseph P. Elliott, Jr., MD, Detroit

PRESIDING: Doctor Elliott

SPEAKERS/SUBJECTS:

Michalene McPharlin, RN, Supervisor, Clinical Vascular Laboratory, Henry Ford Hospital, Detroit

"Doppler Evaluation of Peripheral Arterial Disease"

Daniel J. Reddy, MD, Staff Surgeon, Vascular Surgery, Henry Ford Hospital, Detroit

"Non-Invasive Evaluation of the Asymptomatic Carotid Bruit"

Roger F. Higgins, PhD, Director, Vascular Surgery Laboratory, Harper Hospital, Detroit

"Ultrasonic Arteriography in Carotid Artery Disease"

Joseph P. Elliott, Jr., MD, Director, Clinical Vascular Laboratory, Henry Ford Hospital, Detroit

"Detection of Deep Venous Thrombosis by Phleborrhography"

Gordon Beute, MD, Department of Diagnostic Radiology, Henry Ford Hospital, Detroit

"Arterial Evaluation with Ultrasound and CT"

☐ **Prepaid Health Plans: Alternate Medical Care?**

PRESENTED BY: MSMS Advisory Committee to Bureau of Economics

Prepaid health plans can have a significant impact on community health care delivery. Physicians attending this course will become better able to evaluate the possibility of forming a prepaid group and to operate it in a manner which will assure quality care. The specific areas for course discussion are physician and hospital relations, legal structure and issues, government regulations, analysis of the market and financial considerations. Physicians will be able to use the course information to decide whether it would be more advantageous to develop a plan based on medical principles, or to allow other interested parties to create patterns of care. Additionally, physicians will be able to understand the basic concepts of prepayment in order to effectively deal with issues such as government involvement and impact decisions on the basic types and forms of medicine evolving from this type of financing mechanism.

COURSE DIRECTOR: Jay K. Harness, MD, Ann Arbor

PRESIDING: Doctor Harness

SPEAKERS/SUBJECTS:

Jay K. Harness, MD, Ann Arbor, Chairman, MSMS Advisory Committee to Bureau of Economics

"Organized Medicine's Interest in Prepaid Plans"

Patrick B. Devlin, Acting Chief, Division of Health Maintenance Organizations, Michigan Department of Public Health, Lansing

"Government Regulations and Assistance for HMOs"

Frederick W. Van Duyne, MD, Medical Director, Genesee Health Care, Flint

"Inter-Physician Relationships Within an IPA"

Louis Segladelli, Director, University of Michigan HMO Development Office, Ann Arbor

"Marketing and Cost Controls of an HMO"

Kenneth J. LaMotte, attorney, Kerr, Russell & Weber, Detroit
"Legal Issues of Prepaid Health Plans"

Edward Petras, HMO Consultant, Minneapolis, MN

"What Are the Right Market Conditions for Establishing Pre-Paid Plans"

Thursday morning/continued

☐ **Workshop on Medical Ethics**

PRESENTED BY: Medical Humanities Program, Michigan State University College of Human Medicine

This workshop will develop the idea that conflicts exist between medical decisions based on a scientifically motivated curiosity to diagnose a disease and medical decisions based on the best interest of the patient. Cases will be presented in which alternative workups have been developed according to each of these paradigms. The course will be divided into three periods of approximately one hour each: 1. Plenary session in which the cases are presented and short statements on the ethical, resource allocation, and legal implications of the two approaches are given by members of the panel. 2. Small group discussions with each group being led by a member of the panel. 3. A concluding plenary session, with an attempt to summarize the group discussions.

COURSE DIRECTOR: Andrew D. Hunt, MD, Coordinator, Medical Humanities Program, Michigan State University College of Human Medicine

PRESIDING: Doctor Hunt

SPEAKERS

Bruce Miller, PhD, Associate Professor, Department of Philosophy, Michigan State University

Howard Brody, MD, PhD, Assistant Professor, Department of Family Practice; Assistant Director, Medical Humanities Program, Michigan State University College of Human Medicine

Daniel Bronstein, JD, Associate Professor, Resource Development Department; Associate Professor of Psychiatry, Michigan State University College of Human Medicine

Sumer Verma, MD, Assistant Dean, Department of Human Medicine; Associate Professor, Department of Psychiatry, Michigan State University College of Human Medicine

Arthur F. Korhman, MD, Associate Dean for Educational Programs, Michigan State University College of Human Medicine

Courses Thursday afternoon, Nov. 20

All courses run from 1:30 to 5 p.m. with half-hour break

☐ **Arthrographic, Arthroscopic and Clinical Findings in Knee Injuries**

PRESENTED BY: Michigan Radiological Society

This course will review the basic anatomy of the knee and include correlation of the arthrographic, arthroscopic and clinical findings in injuries of the knee. The course will include discussion by a radiologist and an orthopaedist on indications for the study and technical aspects of both procedures.

COURSE DIRECTOR: Robert A. Songe, MD, Clinical Assistant Professor of Radiology, Wayne State University School of Medicine

PRESIDING: Doctor Songe

SPEAKERS/SUBJECTS:

Lawrence G. Morawa, MD, Clinical Assistant Professor, Department of Orthopaedic Surgery, Wayne State University School of Medicine

"Anatomy of the Knee"

Lawrence F. Campbell, MD, radiologist, Oakwood Hospital, Dearborn

"Arthrographic Diagnosis of Knee Injuries"

Doctor Morawa

"Clinical Diagnosis of Injuries of the Knee"

☐ **Cardiac Arrhythmias — Rational Use of Drugs**

PRESENTED BY: Department of Medicine, Henry Ford Hospital

This course will review the common arrhythmias and will include discussion of where and when to treat this condition. Also included will be a discussion of common clinical pharmacological problems in the use of drugs.

COURSE DIRECTOR: Thomas Killip, MD, Detroit

PRESIDING: Doctor Killip

SPEAKERS:

Thomas Killip, MD, Chairman, Department of Internal Medicine, Henry Ford Hospital, Detroit; Clinical Professor of Internal Medicine, University of Michigan Medical School

G. Paul Stec, MD, Chief Medical Resident and Clinical Pharmacologist, Henry Ford Hospital, Detroit

☐ **Care of the Injured Child**

PRESENTED BY: Division of Pediatric Surgery, Henry Ford Hospital, Detroit

The purpose of this course is to familiarize primary physicians and emergency physicians in the initial management of injured children, to teach the newest concepts of diagnosis and care, long term follow up and prevention of complications. Upon completion of this course, a physician should feel more comfortable in caring for injured children.

COURSE DIRECTOR: Arthur S. Besser, MD, Division Head, Pediatric Surgery, Henry Ford Hospital, Detroit

PRESIDING: Doctor Besser

SPEAKERS/SUBJECTS:

Barry Evans, MD, Director, Pediatric Intensive Care Unit, Henry Ford Hospital, Detroit

"Initial Management of the Injured Child"

Harry Applebaum, MD, Senior Staff Pediatric Surgeon, Henry Ford Hospital, Detroit

"Management of Duodenal, Pancreatic and Renal Injuries"

Ghaos Malik, MD, Senior Staff Pediatric Neurosurgeon, Henry Ford Hospital, Detroit

"Management of Head Injuries"

E. Dennis Lyne, MD, Head, Division Pediatric Orthopedic Surgery, Henry Ford Hospital, Detroit

"Management of Sports Injuries"

Thursday afternoon/continued

Joseph Lewis, MD, Senior Staff Pediatric Cardio-Thoracic Surgeon, Henry Ford Hospital, Detroit

"Management of Cardio-Thoracic Injuries"

Robert J. Touloukian, MD, Chief, Pediatric Surgeon, Yale University, New Haven

"Management of Splenic and Hepatic Injuries"

☐ **Common Thoracic Problems**

PRESENTED BY: Michigan Society of Thoracic Surgeons

This course will try to familiarize practicing physicians with certain thoracic conditions which are fairly common. Speakers will discuss emphysema, which is increasingly being recognized as a significant cause of disability. Included will be discussion of what forms are amenable to surgery. Another topic for discussion will be the surgical removal of certain lymphomas which are confined to the lung. Another specialist will talk about surgery as an effective means of therapy for heart disease caused by constrictive pericarditis. Finally, since so many physicians have patients who need a respirator, there will be information presented on its use and abuse.

COURSE DIRECTOR: **Raymond J. Barrett, MD**, Southfield, Secretary-Treasurer, Michigan Society of Thoracic Surgeons

PRESIDING: **Doctor Barrett**

SPEAKERS/SUBJECTS:

William Lees, MD, Clinical Professor of Surgery, Loyola University of Chicago Stritch School of Medicine, Maywood

"The Role of Surgery in the Treatment of Emphysema"

Philip E. Bernatz, MD, Consultant, Department of Surgery, Mayo Clinic, Rochester

"Thoracic Lymphomas"

Rodman E. Taber, MD, Clinical Associate Professor of Surgery, Wayne State University School of Medicine

"Surgical Results of Pericardectomy"

Thomas J. Petz, MD, Clinical Associate Professor of Internal Medicine, Wayne State University School of Medicine

"Use and Abuse of the Respirator"

☐ **Current Concepts in the Medical and Surgical Management of Ischemic Heart Disease**

PRESENTED BY: Michigan Chapter, American College of Chest Physicians

This course will familiarize all physicians with current problems in the diagnosis and treatment of coronary insufficiency. The course instructors are members of the clinical faculty of Wayne State University School of Medicine and are involved in the daily management of patients with this disease. The discussion of esoteric concepts will be avoided. Participants in this course, when presented with a patient with possible coronary insufficiency, should be able to outline indicated non-invasive and invasive diagnostic tests and medical, surgical or combined treatment.

COURSE DIRECTOR: **Agustin Arbulu, MD**, Detroit

PRESIDING: **Doctor Arbulu**

SPEAKERS:

Sandra M. Leitner, MD, Clinical Instructor, Department of Medicine, Wayne State University School of Medicine

Stanley B. Wolfe, MD, Clinical Assistant Professor, Department of Medicine, Wayne State University School of Medicine

Joseph S. Bassett, MD, Clinical Assistant Professor of Surgery, Wayne State University School of Medicine

Agustin Arbulu, MD, Clinical Professor of Surgery, Wayne State University School of Medicine

☐ **Muscle Contractions, Fiber Types and the Effect of Exercise Training**

PRESENTED BY: Michigan Academy of Physical Medicine and Rehabilitation

The participant should be able to identify the components of the sarcomere, their contribution to the contractile process and their differences in relation to fiber types. Finally one should leave the course with the ability to list some changes in the contractile and non-contractile elements of muscles that follow endurance and strengthening exercise training.

COURSE DIRECTOR: **Charles J. Danek, MD**, Chairman, Education Committee, Michigan Academy of Physical Medicine and Rehabilitation; Practicing Physician, Traverse City

PRESIDING: **Doctor Danek**

SPEAKER/SUBJECT:

Gerald J. Herbison, MD, Director of Research Rehabilitation Medicine, Thomas Jefferson University Hospital, Philadelphia

"Muscle Contractions, Fiber Types and the Effect of Exercise Training"

☐ **Nuclear Medicine: Better Use of Available Tests**

PRESENTED BY: Michigan College of Nuclear Medicine Physicians

The course is designed to reacquaint the practicing physician with diagnostic nuclear medicine studies. Stress will be placed on appropriate utilization, relationship with other diagnostic modalities, and on some of the newer aspects of nuclear medicine. Attendees can expect to gain a better understanding of how nuclear medicine can aid in the diagnosis and management of common clinical problems.

COURSE DIRECTOR: **Daniel S. Marks, MD**, Detroit

PRESIDING: **Doctor Marks**

SPEAKERS/SUBJECTS:

Lawrence Muroff, MD, Clinical Associate Professor of Radiology, South Florida Medical College; Director, Department of Nuclear Medicine, University Community Hospital, Tampa

"A Sensible Approach to Diagnostic Imaging for the Referring Physician"

Darlene Fink-Bennett, MD, Assistant Clinical Professor of Radiology, Michigan State University College of Human Medicine; Assistant Director, Department of Nuclear Medicine, William Beaumont Hospital, Royal Oak

"Nuclear Cardiology – Its Value to the Practicing Physician"

Joel Hamburger, MD, Director, Northland Thyroid Laboratory, Southfield

"Modern Thyroid Function Tests"

Daniel S. Marks, MD, Head, Division of Nuclear Medicine, Henry Ford Hospital, Detroit

"Clinical Usefulness of Bone Scans and Gallium Studies"

☐ **Office Management of Common Infectious Problems**

PRESENTED BY: Division of Infectious Diseases, Butterworth Hospital, Grand Rapids

Advanced CLS course offered Nov. 19-20

For the third year in a row, the MSMS Annual Scientific Meeting will include a special two-day course in the nationally-recognized Advanced Cardiac Life Support training and certification program.

The course, planned Wednesday and Thursday, Nov. 19 and 20, will award 16 Category I credit hours. In addition, candidates who successfully complete the testing according to American Hospital Association standards will be certified as providers in ACLS by the Michigan Heart Association.

The Michigan Chapter, American College of Emergency Physicians is presenting the course, which runs eight hours each day.

The Course Director is Craig E. Downs, DO, Director of Emergency Medical Services, Lansing General Hospital, Lansing.

The course will be limited to 48 physicians who have completed the basic CLS course. A three-hour Basic Life Support course will be offered Tuesday afternoon, Nov. 18 for anyone who might then want to go on to the advanced course on Wednesday and Thursday. Prior CPR practice is highly recommended.

Select courses of practical value:

Enroll today . . . take your choice . . .

9 courses, Tuesday morning, Nov. 18 — See pages 2, 3 and 4

8 courses, Tuesday afternoon, Nov. 18 — See pages 5, 6 and 7

11 courses, Wednesday morning, Nov. 19 — See pages 8, 9 and 10

10 courses, Wednesday afternoon, Nov. 19 — See pages 11, 12, and 13

7 courses, Thursday morning, Nov. 20 — See pages 14, 15 and 16

9 courses, Thursday afternoon, Nov. 20 — See pages 16, 17 and 18

For registration form — see page 19

Physicians must register for the ACLS course before Oct. 3. They will be sent an extensive packet of study materials and instructions. The American Heart Association CLS texts will be followed.

Interested physicians should use the registration form on page 19 of this issue to make arrangements to attend this course. A fee will be charged to cover costs of study materials, and for a special trained faculty.

The course consists of lecture material and concepts in training and testing for the practical skills in ACLS.

Lectures will deal with adjuncts for airway and ventilation, circulation, monitoring and dysrhythmia recognition, defibrillation and synchronized cardioversion and establishment of IVs. Eight stations will be used to train the participants in ACLS skills.

Michigan State Medical Society
120 West Saginaw Street
East Lansing, Michigan 48823

MICHIGAN MEDICINE

Vol. 79 No. 25, September 9, 1980

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Editor: Judith Marr

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CAPSULES

MSMS IS READY to begin its presentation Sept. 22 when the Federal Trade Commission case against MSMS is scheduled to resume. The FTC, which is charging MSMS with illegal coercion of Blue Cross Blue Shield of Michigan, presented its case in June. The MSMS trial brief runs 60 pages, according to A. Stewart Kerr, MSMS legal counsel. MSMS has lined up 11 witnesses, and Mr. Kerr expects the MSMS presentation to last approximately two weeks. "When the FTC concluded its case in June," said Mr. Kerr at MSMS headquarters Sept. 10, "we were in as good a position as we could be." There is a possibility that either or both sides also will have rebuttal testimony at a later date.

In this issue . . .

are two special features. Please complete and return the survey of MSMS members' insurance preferences and the registration form for the MSMS Public Affairs/Leadership conference planned Oct. 30 in Lansing.

Physicians completing the insurance survey simply may detach that page, fold in thirds with the mailing information portion out, staple shut and drop in the mail. Please act today on these important issues!

MEDIGRAM

MSMS Council highlights

At its Sept. 10 meeting, the MSMS Council:

1. Joined in the Wayne County Medical Society's posthumous nomination of Robert E. Rice, MD, Greenville, for the AMA's Benjamin Rush Award for citizenship and community service. The Chairman and the President will sign the letter of nomination.
2. Officially commended the Michigan Physicians Mutual Liability Company "for its substantial progress," and suggested to all Michigan physicians that they may purchase malpractice and professional premises coverage from MPMLC "with complete confidence in its stability and in the splendid character of the services it renders."
3. Approved appointments to a new MSMS Task Force on Study of New Reimbursement Systems, which was authorized by a 1980 MSMS House of Delegates resolution.
4. Supported recommendations of a report on Nursing Requirements and Resources for Michigan 1985-1990 commissioned by the state Office of Health and Medical Affairs. The report recommends several actions to ensure an adequate supply of nurses. The MSMS Council qualified its support by saying more accurate, and better interpreted, data was needed. The Council said MSMS should cooperate in efforts to meet the need for nurses.
5. Voted to enlarge the PSRO Liaison Committee, to better carry out the intent of the 1980 MSMS House of Delegates resolution to support physicians involved in PSROs around the state and to encourage MSMS members to serve on their local PSROs.

Register today! for the 1980 MSMS Annual Scientific Meeting

The 1980 MSMS Annual Scientific Meeting Nov. 18-19-20 at the Hyatt Regency Dearborn is fast approaching. Physicians must register early to guarantee their first choice of courses. Some courses, particularly the one on Advanced Cardiac Life Support, are limited in enrollment, with reservations taken on a first-come, first-serve basis. Registration for the ACLS course must be made by Oct. 3. Full information and registration forms appear in the September Michigan Medicine and Sept. 9 Medigram. Registration information also is available from Sherry Fent at MSMS headquarters.

Please fill out and return this survey of MSMS group health insurance options

The Michigan State Medical Society is studying possible additions to its present group health insurance coverage. A number of plans have been reviewed, and The Council has requested a poll to determine members' interests in additional types of coverages.

Rates are a major factor when making decisions regarding insurance coverage. Unfortunately, it is not possible to publish the rates for each option at the present time. If the membership indicates it desires additional coverage, MSMS will negotiate the best possible rates.

Please fill out the enclosed self-addressed questionnaire and mail by Oct 1. The Council would like to discuss this issue at its mid-October meeting.

Part I

With which of the following do you agree?

MSMS should continue to offer to its members BCBSM coverage on a group basis.

☐ Agree ☐ Neutral ☐ Disagree

MSMS should seek similar coverage from other commercial carriers.

☐ Agree ☐ Neutral ☐ Disagree

Part II — Present Coverage

1. I feel the present options offered by the Society are sufficient. (Basic BCBSM coverage — MVF-2. No out-patient or drug options. Presently a Blue Cross-only policy and a 30 percent deductible policy also are available.)

☐ Strongly Agree ☐ Agree ☐ Neutral
☐ Disagree ☐ Strongly Disagree

2. I feel the addition to the present BCBSM coverage of a master medical program would make a better policy for my needs. (This option would cover out-patient services after a small deductible is met.)*

☐ Strongly Agree ☐ Agree ☐ Neutral
☐ Disagree ☐ Strongly Disagree

Part III — Additional Coverage

1. I would like to see the addition of a drug program.*

☐ Strongly Agree ☐ Agree ☐ Neutral
☐ Disagree ☐ Strongly Disagree

2. In my opinion MSMS should offer catastrophic coverage to its insurance programs. (Basically a \$1,000 deductible and co-pay policy covering both hospitalization and out-patient services.)

☐ Strongly Agree ☐ Agree ☐ Neutral
☐ Disagree ☐ Strongly Disagree

3. I would consider purchasing a dental program.

☐ Strongly Agree ☐ Agree ☐ Neutral
☐ Disagree ☐ Strongly Disagree

Part IV

Are you presently insured through the MSMS group coverage?

☐ Yes ☐ No

**The master medical and drug programs cannot be individual options, but would apply to all members of the group.*

(Please tear off this page, letterfold with business reply panel out and tape closed)



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Sign Up Now!

**Sen. Carl Levin
to keynote
MSMS Public Affairs
Leadership Conference**



The First Annual MSMS Public Affairs Leadership Conference is being held on Oct. 30 at Long's Convention Center, Lansing.

The 1980 MSMS House of Delegates enthusiastically challenged MSMS and the medical community to make an aggressive effort to prepare and inform physician leaders. Thus, this program will concentrate

on those professional, socio-economic, political and administrative trends, ideas and problems that are clearly and, in some cases, ominously, visible on the professional horizon for every practicing physician today.

This promises to be a day well spent in professional growth and fellowship!

The program

9:00 REGISTRATION

9:30 CALL TO ORDER — John R. Ylvisaker, MD, MSMS President

9:45 "AMERICA AT THE POLLS" — Richard Scammon, Director, Elections Research Center, Washington, DC

10:45 "POLITICAL ACTION — MDPAC" — Thomas C. Payne, MD, Chairman, Michigan Doctors Political Action Committee

11:00 "FEDERAL TRADE COMMISSION DEVELOPMENTS" — Louis R. Zako, MD, Chairman, Michigan State Medical Society Council

11:15 "ON THE STAND . . ." — A. Stewart Kerr, MSMS Legal Counsel, Kerr, Russell and Weber, Detroit

11:30 "REVIEW, PREVIEW AND PROGNOSTICATIONS FROM THE UNITED STATES SENATE" — Honorable Carl Levin, United States Senator

12:15 LUNCH — Luncheon Speaker, Robert T. Kelly, MD, Minnesota, AMA Board of Trustees

1:30 "INTERNAL OPERATIONS AT MSMS HEADQUARTERS" — Thomas Berglund, MD, Vice-Chairman, MSMS Council

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3:30 "THE NATURE OF LEADERSHIP IN MEDICINE: There's a Lot We Physicians Can Do" — Ed Annis, MD, Former AMA President, Presently — Consultant, Mutual Association for Professional Services

Please return to:

**1980 Public Affairs Leadership Conference
Michigan State Medical Society
P.O. Box 950
East Lansing, Michigan 48823**

Name _____

City _____

Name _____

City _____

For telephone reservations:
Please contact Bill Madigan
or Kevin Kelly
at MSMS Headquarters —
517/337-1351.

Please check one

☐ Physician ☐ Other _____

Registration Fee: \$25 includes luncheon

Amount enclosed \$ _____

Please make check payable
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CAPSULES/continued

MSMS PRESIDENT John R. Ylvisaker, MD, brought greetings from MSMS to the annual meeting Sept. 12 and 13 of the Upper Peninsula Medical Societies. The UPMS meeting was held at the Grand Hotel, Mackinac Island, and combined business and scientific activities.

MICHIGAN SUPREME COURT Sept. 12 ruled the Tisch tax reform proposal should appear on the November general election ballot. The Tisch proposal, which would have major repercussions for the state's health care system, and other tax reform issues will be described in the October issue of Michigan Medicine. That issue will have a special report on the November elections.

FOR THE FIRST TIME since its inception in 1972, an MSMS Medicaid Liaison Committee meeting has been canceled. The committee's Sept. 25 meeting has been called due to lack of legislative activity toward a Medicaid budget.

BCBSM reform bill moving slowly

MSMS has vital interests in a portion of the Blue Cross Blue Shield of Michigan reform legislation now under discussion by the joint legislative conference committee. The conference committee has discussed the definitions section, particularly the participating contract definition. The Senate version of that definition clearly enables MDs to participate on a "per-claim" basis. The conference committee has met three times, but is moving slower than legislative leaders expected. The committee will meet again Sept. 22.

Doctor Leitch new MPMLC president

Robert M. Leitch, MD, Battle Creek, past MSMS president is the new president and chairman of the board of the Michigan Physicians Mutual Liability Company. Doctor Leitch currently is MSMS secretary, and an alternate delegate to the AMA. In his new MPMLC role, Doctor Leitch will work to provide specialized insurance products, the lowest possible premiums, and the best claims service for physicians in Michigan. (See related item, #2 in Council highlights, page one.)

Oct. 7 physician recruitment day

On Oct. 7, a Michigan Physicians Recruitment Conference is planned at Long's Convention Center by the Michigan Health Council. The conference brings together physicians looking for practice opportunities and Michigan communities recruiting physicians. There are 137 Michigan communities registered with the Health Council and seeking physicians. Further information is available from Herbert A. Auer, executive vice president, Michigan Health Council.

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MICHIGAN MEDICINE

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Editor: Judith Marr

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MEDIGRAM

CAPSULES

OVER \$1 MILLION have been collected by the MSMS/Physician Service Group, Inc.-endorsed collection service. John Anthony, PSG general manager, reports that IC Systems has over 2,000 medical society members using the collection service. "They have saved our members over \$200,000 in collection costs," reports Mr. Anthony. For more information, please call Mr. Anthony or Meredith Fors at MSMS headquarters, 517/337-1351.

MSMS AUXILIARY MEMBERS will meet Oct. 28 at MSMS headquarters for a seminar on public speaking. Dubbed "Grand Rounds," the seminar is to prepare the auxiliaries to represent organized medicine's views in a newly-planned MSMS/A speakers bureau.

In this issue . . .

are two registration forms. The first is for the outstanding MSMS Public Affairs Leadership Conference Oct. 30 at Long's Convention Center, Lansing. Speakers will be U.S. Sen. Carl Levin, national elections research expert Richard Scammon, and former AMA President Edward Annis, MD. The second is for the three-day MSMS Annual Scientific Meeting, Nov. 18-20 at the Hyatt Regency Dearborn. Physicians should complete and return the ASM registration form soon as courses are filling. Registrations so far this year exceed last year's, when 1,600 MDs attended the meeting.

MSMS/FTC trial going well

MSMS legal counsel is pleased with developments to date in the case of the Federal Trade Commission vs. MSMS. The FTC is suing MSMS for alleged illegal coercion of Blue Cross Blue Shield of Michigan. As this Medigram went to press, MSMS Chief Legal Counsel A. Stewart Kerr expected to rest the MSMS case by Oct. 10. The start of MSMS testimony was delayed one week until Sept. 29, due to a death in the family of William Sankbeil, one of the MSMS attorneys. MSMS shortened from 11 to six the list of witnesses it planned to call on during the trial. "Obviously we are pleased or we wouldn't be shortening the list," commented Mr. Sankbeil. "We are very satisfied with the case as it has gone so far and don't see any need to call on the other witnesses we had planned." Frank Sloan, PhD, Vanderbilt University economist, had to testify yet as this report was written. Among the witnesses were John T. Dempsey, PhD, director, Michigan Department of Social Services; Donald K. Crandall, MD, Muskegon surgeon; Keith Leffler, PhD, University of Washington economist, and David Siegel, MD, Lansing urologist.

In addition to witnesses' testimony, MSMS has entered many documents as evidence.

"The conclusion of our testimony is only the end of one phase of the trial," said Mr. Kerr. (FTC testimony was made in June.) There are several legal steps yet to be taken before the FTC administrative law judge hands down a decision.

MSMS nominates three MDs to medical hall of fame

The MSMS Council has nominated to the All-American Medical Hall of Fame three Michigan physicians whose contributions have historic significance. They are William Beaumont, MD, 1785-1853, for his important Michigan work on the physiology of digestion; Thomas Francis, Jr., MD, 1900-1969, developer of the first effective vaccine for influenza and supervisor of the successful testing of the Salk Polio vaccine, and Frank N. Wilson, MD, 1890-1952, pioneer cardiologist. Norman E. Clarke, MD, Oak Park, did the MSMS research.

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1980 MSMS Annual Scientific Meeting, Hyatt Regency Dearborn Registration Form for Category I CME Courses

* All courses except those marked with asterisks are approved for Prescribed Credit by American Academy of Family Physicians

TUESDAY MORNING, NOV. 18 (8:30 to Noon, including break)

(Write 1 in blank for first choice,
and 2 for second choice)

- ___ Care of the Elderly
- ___ CME Implementation in Community Hospitals
- ___ Current Concepts and Practical Therapeutic Approach to Non-Hodgkins Lymphoma
- ___ Denial in Alcoholism, Substance Abuse and Mental Health
- ___ Management of Problems in Office Gynecology
- ___ Multi-Disciplinary Approach to Back Pain
- ___ Occupational Medicine
- ___ Office Management of Common Pediatric Problems
- ___ The Wet Ear — Diagnosis and Treatment for Primary Care Physicians

TUESDAY AFTERNOON, NOV. 18 (1:30 to 5:00, including break)

(Write 1 in blank for first choice,
and 2 for second choice)

- ___ Basic Life Support
- ___ Brief Psychotherapy by the Primary Physician-Psychoanalyst Team
- ___ Chronic Abdominal Pain
- ___ Current Management of Renal Failure
- ___ Diabetes — Current Management and New Horizons
- ___ Emergency Psychiatry: Theory and Practice
- ___ Physicians as Expert Witnesses: Continuing Medical Care
- ___ Tonsillectomy and Adenoidectomy — Current Status

WEDNESDAY MORNING, NOV. 19 (8:30 to Noon, including break)

(Write 1 in blank for first choice,
and 2 for second choice)

- ___ Advanced Cardiac Life Support (A 16-hour course to run all-day Nov. 19 and 20. See tuition below.)
- ___ Clinical Toxicology in the Emergency Department
- ___ Colon Polyp — Cancer Sequence: A Rational Approach
- ___ Common Orthopaedic Problems
- ___ Dermatology for the Non-Dermatologist
- ___ Effectiveness of Treating Hypertensive Patients: Newer Data
- ___ Genetic Issues in General Practice
- ___ Health Planning: Impact on the Physician and Patient Care
- ___ Psycho-Pharmacology: Anti-Depressants
- ___ Skin Cancer — Including Malignant Melanoma
- ___ Thoracic Trauma: Problems in Diagnosis, Early Management and Disposition

WEDNESDAY AFTERNOON, NOV. 19 (1:30 to 5:00, including break)

(Write 1 in blank for first choice,
and 2 for second choice)

- ___ Bronchial Asthma in Children and Adults
- ___ Current Approaches in Diagnosis and Management of Cancer of the Lung
- ___ Current Concepts in the Management of Electrolyte Disorders
- ___ Diagnosis and Curative Management of Breast Cancer
- ___ Diagnosis and Treatment of Colon and Rectal Disease
- ___ Everything You Always Wanted to Know About Local Anesthetics
- ___ Injuries to the Genito-Urinary Tract
- ___ Management of Difficult Soft Tissue Wounds
- ___ Psycho-Pharmacology: Anti-Anxiety Agents
- ___ Update on Cutaneous Mycology and Bacteriology — 1980

THURSDAY MORNING, NOV. 20 (8:30 to Noon, including break)

(Write 1 in blank for first choice,
and 2 for second choice)

- ___ Chronic Head Pain
- ___ Common Ophthalmic Problems
- ___ Elective Surgical Procedures in the Elderly
- ___ Management of Abortion — Current Aspects
- ___ Non-Invasive Diagnosis of Peripheral Vascular Disease
- ___ Pre-Paid Health Plans: Alternate Medical Care?
- ___ Workshop on Medical Ethics

THURSDAY AFTERNOON, NOV. 20 (1:30 to 5:00, including break)

(Write 1 in blank for first choice,
and 2 for second choice)

- ___ Arthrographic, Arthroscopic and Clinical Findings in Knee Injuries
- ___ Cardiac Arrhythmias — Rational Use of Drugs
- ___ Care of the Injured Child
- ___ Common Thoracic Problems
- ___ Current Concepts in Medical and Surgical Management of Ischemic Heart Disease
- * ___ Muscle Contractions, Fiber Types and the Effect of Exercise Training
- ___ Nuclear Medicine: Better Use of Available Tests
- ___ Office Management of Common Infectious Problems
- * ___ Ophthalmology Symposium



The half-day courses will provide 3 hours of Category I credit toward the state relicensure requirements and the AMA Physician's Recognition Award.

Please check the courses you wish to attend. In each case, please indicate a second choice should the first choice already be filled. Maximum attendance figures have been set for each course because rooms vary in size.

Send this entire page with your check. Confirmation of your reservation will be sent to you. Your course credentials, badge, and luncheon tickets, must be picked up at the MSMS Registration Desk upon arrival at the Hyatt Regency.

Physicians must make their own hotel reservations prior to 11/1/80 direct with the Hyatt Regency Dearborn, Fairlane Town Center, Dearborn, MI 48126. In order to take advantage of the special conference rates, please mention that you will be attending the MSMS Annual Scientific Meeting.

Name _____
(please print) (first) (initial) (last)

Street _____

City, State _____ Zip _____

MSMS Member: Yes _____ No _____ Resident _____ Other _____ Specialty _____

Tuition schedule for courses:

MSMS members: \$5 per credit hour, or \$15 for each half-day course
Non-members: \$10 per credit hour, or \$30 for each half-day course
Residents: \$5 PER COURSE

Luncheon reservations: The hotel will provide luncheon each noon at \$8 per person. Advance reservations are requested so MSMS can give an accurate guarantee. Please indicate which days you want a lunch ticket.

- Tuesday lunch _____ Wednesday lunch _____ Thursday lunch _____
- Indicate total number of half-day courses: _____ × \$15 (members) \$ _____
_____ × \$30 (non-members) \$ _____
_____ × \$5 (residents) \$ _____
- Number of luncheons requested: _____ × \$8 \$ _____
- Registration for special 16-hr. ACLS Course (\$175 incl. lunch): \$ _____
- Total \$ _____

Make checks payable to MSMS and mail to MSMS, Box 950, East Lansing, MI 48823

PHYSICIANS' CONTRIBUTIONS to the Michigan Refugee Relief Fund are greatly appreciated, says Gov. William Milliken. In a letter to MSMS Council Chairman Louis R. Zako, MD, Gov. Milliken praised MSMS for its support of the fund he established after a personal visit to Cambodian refugee camps. Here's what physicians' donations may buy:

- \$1,500 -- 5 tons of rice
- \$1,000 -- 20 deepwell pumps for village water
- \$ 500 -- fish and rice for 100 women and children for one month
- \$ 300 -- A and D vitamins for 1,000 children for one month
- \$ 250 -- fish and rice for 10 families of five for one month
- \$ 210 -- 1,000 pounds of skim milk powder
- \$ 170 -- 100,000 multi-vitamins with iron
- \$ 60 -- fish and rice for 10 men for one month

Please send donations (they are tax deductible) to the Michigan Refugee Relief Fund, Box 55-316A, Detroit, 48255.

FORMS FOR MICHIGAN'S medical arbitration system are available from MSMS at cost. Michigan physicians who wish to distribute them to patients may obtain forms and prices from Mrs. Nancy Wimmer at MSMS headquarters, 517/337-1351.

CHPC-SEM revising debedding plan

The next move in the southeast Michigan hospital bed reduction issue again belongs to the Comprehensive Health Planning Council of Southeast Michigan. In its renewed efforts to shape a bed reduction plan consistent with legislative directives, CHPC-SEM is to follow eight recommendations of the Special Joint Legislative Committee to Investigate the Hospital Bed Reduction Plan for Southeast Michigan (CHPC-SEM). The MSMS Council in March called for a moratorium on bed reductions until some southeast Michigan problems could be worked out. The legislature complied with the intent of this resolution and passed legislation eliminating the first CHPC-SEM plan, thereby creating a moratorium for at least one year. In the interim the special joint committee passed its report to provide direction to CHPC-SEM.

The special committee's action paves the way for the bed reduction process to be revitalized statewide. The Statewide Health Coordinating Council now must resubmit its guidelines and criteria for bed reduction plans to the Joint Legislative Committee on Administrative Rules. Rules Committee approval would allow the second annual bed reduction plan cycle to begin.

Medicaid fate undecided under state's continuation budget

The State of Michigan is operating on a three-month continuation budget for the early 1980-81 fiscal year, which began Oct. 1. House, Senate and Governor approved the continuation Sept. 30. A special legislative committee is to meet continually with Budget Director Gerald Miller to review proposed allotments and disbursements. Funding will be at levels slightly below those of the 1979-80 budget.

"They (the stopgap measures) do not solve our budget problems," said Gov. Milliken, "but merely postpone the time when some final, more permanent cuts must be made." How this will affect Medicaid provider reimbursements for the next 90 days is not decided.

Michigan State Medical Society
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East Lansing, Michigan 48823

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Editor: Judith Marr

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MICHIGAN MEDICINE

October 1980

JOURNAL OF THE MICHIGAN STATE MEDICAL SOCIETY

Vol. 79, No. 29

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Do you know

a physician
with problems
of alcoholism,
drug abuse,
or other
difficulties
which interfere with
his/her abilities
to practice medicine?

*If so, please contact
your MSMS Committee to
assist Impaired Physicians
through Marce Ireland at MSMS
headquarters (517) 337-1351.*



MSMS serves physicians in many ways

MMSMS represents you and your colleagues in public health and welfare programs.

MSMS interprets you — your training, your motives, your problems, your professional aims and objectives — to your community.

MSMS tries to nurture a favorable public concern toward your profession by helping people to understand and appreciate medicine's contribution.

MSMS guides the development of medical practice in relation to other callings and economic groups.

MSMS protects your legal status as a doctor.

MSMS helps keep medical competition on a professional plane.

MSMS helps your profession to meet its collective responsibilities to the public and avoids the necessity of the public resorting to political devices to solve these problems.

MSMS regularly offers outstanding continuing medical education programs to keep you abreast of the latest and most effective medical theories and techniques.

MSMS provides for you those personal benefits, services, and representations impossible to secure and maintain as an individual.

MSMS helps you to survive and have your voice heard as a responsible professional in an increasingly interdependent and socialized society.



Our flag is the symbol of our country, and it's our country we're talking about in this issue of *Michigan Medicine*. More especially, it's the continuance of our country's government through the general elections next month. Articles in our special report are designed to help inform Michigan physicians and help them gauge the impact of the elections on the practice of medicine here. (Photo by Mert Scholten)

MICHIGAN MEDICINE

October 1980, Volume 79, Number 29

Special report

516 In November, this country chooses a president, a party and a philosophy to guide it during the coming four years. These decisions will have major impact on every phase of our lives, and health care delivery has much at stake. To help Michigan physicians prepare for making their choices in November, this issue of *Michigan Medicine* presents information on the party platforms, and philosophies, statewide ballot issues and activities of MDPAC during its busiest season; Melvin Larsen, Olivia Maynard, and Kevin Kelly

Features

- 524** MSMS jail health project provides unique training seminar for sheriffs' departments; David Schut
- 526** MSMS group health premiums expected to rise only 5.4 percent in 1980
- 529** American Academy of Pediatrics returning to its birthplace, Detroit, for golden anniversary annual meeting; Dwight Angell
- 540** Time yet to register for 1980 MSMS Annual Scientific Meeting
- 554** Plan now for 1980 MSMS Public Affairs Leadership conference Oct. 30 in Lansing

Departments

- 512** Editorial; Busharat Ahmad, MD
- 513** Letters
- 526** Ad Index
- 538** Peer review exchange; Bernard H. Smookler, MD
- 542** Meetings
- 544** Category I courses
- 548** MSMS/A; Donna Chase
- 550** News; Bonnie L. Groff
- 555** Classified ads
- 556** President's page; John R. Ylvisaker, MD

Ask a foreign-born colleague about the privilege of voting

By Busharat Ahmad, MD, Marquette



By the time you read this article, there will be less than four weeks left before the election. For those of us who have not involved ourselves in this most democratic of all processes, it is still not too late. We will elect our representatives, not only on the national level but also on the state and local level, who make the laws that eventually effect all of us. Our input is especially important not only individually but collectively for the preservation of this, our most precious heritage.

Voting, a privilege and a right that we take so much for granted, is not available to more than half the world. The people of that other half would give anything for the right to vote to elect those who would truly represent them and would govern them in the most democratic fashion. If you doubt this is true, all you have to do is ask one of your colleagues who has come here from one of those countries, especially from behind the Iron or Bamboo Curtains. I hope we will not forget to exercise that important right on the day of the election.

Involvement in the election process is especially important to our profession, more so now than ever before. Our fate and that of the free enterprise of medicine may be decided on Capitol Hill.

We have seen in recent days how the practice of medicine is being changed and controlled by legislative process despite the efforts of organized medicine. We have also seen how some of the paramedical groups have made inroads into the practice of medicine, not by education and training, but through legislation.

The best opportunity to reshape our country's future is to involve ourselves in this election process, not only as members of the society but especially as physicians. We all are respected members of our communities and our voice is heard not only by our patients but also by our neighbors. This is more true than we sometimes realize.

We should all take time to involve ourselves by spending more time with the people we can influence, i.e. the electorate. We can man booths of the party of our choice, take active part in MDPAC, and AMPAC, and in our specialty society PAC.

I urge you to talk to your Congressman on your views, develop a personal relationship with him by taking him out to lunch or dinner and letting him know you are concerned and interested not only in him but also in what he does.

Do that now before the election, do it during the election and keep doing it after the election is over. The Democratic process does not stop on Nov. 4. You will feel better for doing so and will be of great help to yourself, your community, your country and above all to your profession.

Doctor Ahmad is MSMS councilor from the Twelfth District, and is vice chairman of the MSMS Committee on Publications.

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Editor

Judith Marr

Michigan Medicine, the official journal of the Michigan State Society, is dedicated to provide useful information for Michigan physicians about actions of the Michigan State Medical Society and contemporary issues, with special emphasis on socio-economics, legislation and news about medicine in Michigan. Major medical developments will be reported and interpreted as has been the custom.

The Michigan State Medical Society Committee on Publications is the editorial board of Michigan Medicine and advises the editors in the conduct and policy of the magazine, subject to the policies of the MSMS Council.

Neither the editors nor the state medical society will accept responsibility for statements made or opinions expressed by any contributor in any article or feature published in the pages of the journal. The views expressed are those of the writer and not necessarily official positions of the society. Products and services advertised in Michigan Medicine are neither endorsed nor warranted by MSMS.

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“... treating certain parasites in Asian refugees.”

While I was reading the July, 1980 edition of *Michigan Medicine*, I came across an article on page 359 on treatment protocols for parasite control in Asian refugees. Included in this article was a table supposedly reprinted from the Ingham County Health Department Newsletter.

I believe there is some misinformation in this table. Since I have previously treated many refugee children and have spoken directly with the Center for Disease Control (CDC) in Atlanta, Georgia, about anti-parasitic chemotherapy regimens, I felt I must identify this misinformation and suggest alternative therapy.

“... to inform your members of the recommendations on infants' and children's eye care ...”

The American Academy of Ophthalmology recently submitted a statement on infant and children's eye care to The Federal Health and Human Sciences Department's Select Panel for the Promotion of Child Health.

The statement explains the need for early screening and treatment of eye problems in children and suggests when and where screening should occur. Other recommendations address referral of children with visual deficiencies, counseling and rehabilitation for those who are visually impaired or blind, and public and interprofessional education on children's eye care. Federal government support for screening and eye care and the role of vision in learning disabilities are also covered.

We would like to inform your members and others of the recommendations and reasons behind them.

Copies of our statement are available from our office.

Bruce E. Spivey, MD
Executive Vice President
American Academy of
Ophthalmology
1833 Fillmore, PO 7474
San Francisco, CA 94120

First, *Clonorchis sinensis*, the “liver fluke,” is a very difficult parasite to treat. The Parasitic Disease Drug Service of CDC, as recently as three months ago, has been recommending no therapy, unless the patient has jaundice or evidence of portal (liver) obstruction. Many different drug regimens have been tried, but with limited success in eradication of this parasite. Chloroquine supposedly only temporarily suppresses ova.

Second, the most effective therapy for *Strongyloides stercoralis*, “thread-worm,” is not Vermox[®]. Thiabendazole or Mintezol[®] is the most effective therapy.

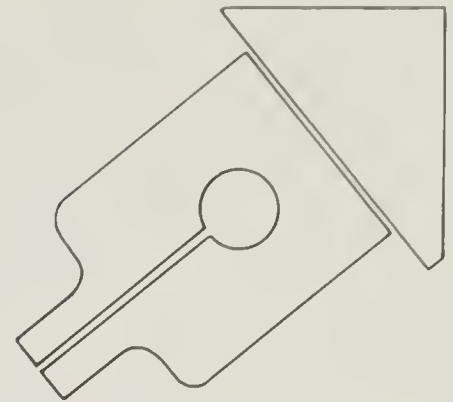
Finally, *Hymenolepis nana*, the “dwarf tapeworm,” is best treated with Niclosamide or Yomesan,[®] not Atabrine.[®] This medication is only available from the Parasitic Disease Drug Service at CDC (phone number 404-633-3311 ext. 3670). Niclosamide is also approved for use in infestations with *Taenia saginata* and *Diphyllobothrium latum*. Since *Hymenolepis nana* can be transferred from one person to another without an intermediate host, its treatment is essential. The success rate for Niclosamide in *Hymenolepis nana* infections is far superior to other drug regimens. Niclosamide is also one of the more benign anti-parasitic medications.

I hope the above information will help clear up any problems physicians may have in treating certain parasites in Asian refugees.

Sincerely,

Dennis L. Murray, MD
Assistant Professor
Department of Pediatric/Human
Development
Immunology/Infectious Disease
Section
Michigan State University

Editor's note: *Michigan Medicine* appreciates Doctor Murray's comments, and wishes to point out the table in the July issue provided parasite treatment protocols for adults only.



“... writing you to introduce you to the National Emergency Network ...”

I am writing to introduce your Medical Society to the National Emergency Network, a new worldwide patient identification system and emergency service developed by emergency physicians, emergency nurses, and rescue personnel.

You and your associates are invited to review a brochure describing this unique program. We would appreciate it if the members of the medical society, including the emergency physicians, could be informed of this service, and we would be delighted to answer any questions they may have.

Sincerely,

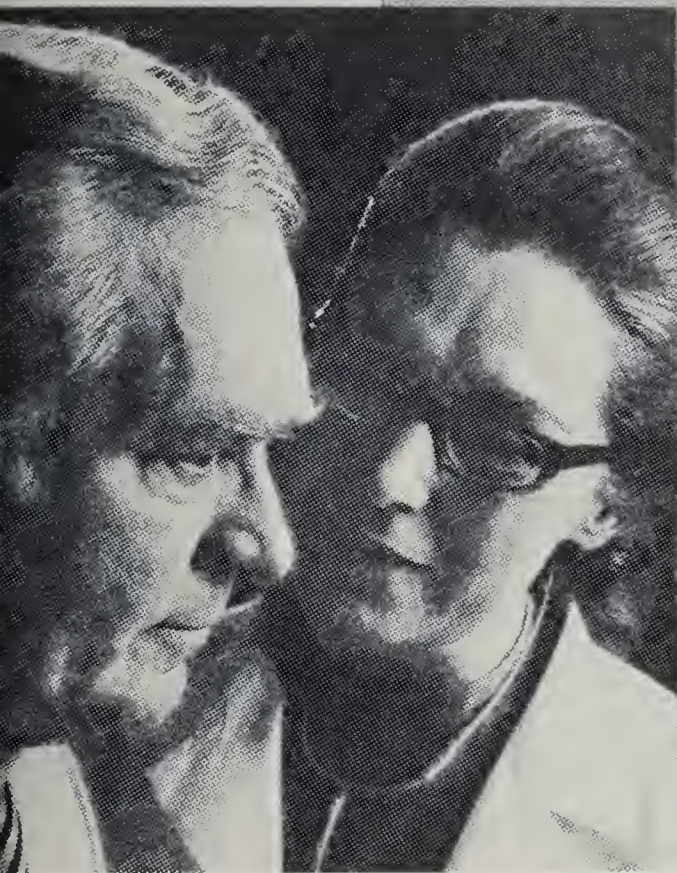
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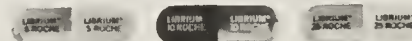
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The published record on Librium is enormous. So large, in fact, it had to be put into a computer data bank and retrieval system. It's a record that shows Librium is highly effective in relieving anxiety; that Librium is seldom associated with serious side effects; that Librium rarely interferes with mental acuity at proper doses; that Librium is used concomitantly with primary medications. However, as with all CNS agents, patients should be warned against hazardous activities requiring complete alertness, and about possible combined effects with alcohol.

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Please see next page for summary of product information.

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chlordiazepoxide HCl/Roche

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Relief of anxiety and tension occurring alone or accompanying various disease states. Efficacy beyond four months not established by systematic clinical studies. Periodic reassessment of therapy recommended.

Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Warn patients that mental and/or physical abilities required for tasks such as driving or operating machinery may be impaired, as may be mental alertness in children, and that concomitant use with alcohol or CNS depressants may have an additive effect. Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported.

Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression, suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants, causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction, changes in EEG patterns (low-voltage fast activity) may appear during and after treatment, blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

Usual Daily Dosage: Individualize for maximum beneficial effects. *Oral—Adults:* Mild and moderate anxiety and tension, 5 or 10 mg t.i.d. or q.i.d.; severe states, 20 or 25 mg t.i.d. or q.i.d. *Geriatric patients:* 5 mg b.i.d. to q.i.d. (See Precautions.)

Supplied: Librium[®] (chlordiazepoxide HCl) Capsules, 5 mg, 10 mg and 25 mg—bottles of 100 and 500, Tel-E-Dose[®] packages of 100, available in trays of 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10; Prescription Paks of 50, available singly and in trays of 10. Libritabs[®] (chlordiazepoxide) Tablets, 5 mg, 10 mg and 25 mg—bottles of 100 and 500. With respect to clinical activity, capsules and tablets are indistinguishable.

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SPECIAL REPORT



It's a grand old flag . . .

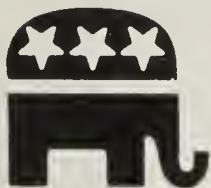
and this fall we carry out one of our most important duties to ensure that it waves long o'er those of us privileged to live in our democracy.

We vote!

To help Michigan physicians vote intelligently, we asked some questions.

What are the national political parties seeking in this 1980 general election? What do the state political leaders think about this election as it relates to Michigan physicians? What are the issues on the Michigan ballot and what is their intent? What is MDPAC doing as presidential, congressional and legislative candidates work for election?

We hope we've provided some answers in the special report which continues on the next few pages. We invite MSMS members to read these pages, and to send us their own observations on the political scene in this electric time in our country's life.



The Republicans' national views on health care

"Our country's unequalled system of medical care, bringing greater benefits to more people than anywhere else on earth, is a splendid example of how Americans have taken care of their own needs with private institutions.

"Significant as these achievements are, we must not be complacent. Health care costs continue to rise, farther and faster than they should, and threaten to spiral beyond the reach of many families. The causes are the Democratic Congress' inflationary spending and excessive and expensive regulations.

"Republicans unequivocally oppose socialized medicine, in whatever guise it

is presented by the Democratic Party. We reject the creation of a national health service and all proposals for compulsory national health insurance.

"Our country has made spectacular gains in health care in recent decades. Most families are now covered by private insurance, Medicare, or in the case of the poor, the entirely free services under Medicaid.

"Republicans recognize that many health care problems can be solved if government will work closely with the private sector to find remedies that will enhance our current system of excellent care. We applaud, as an example, the voluntary effort which has been undertaken by our nation's hospitals to control costs. The results have been encouraging. More remains to be done.

"What ails American medicine is government meddling and the strait-jacket of federal programs. The prescription for good health care is deregulation and an emphasis upon consumer rights and patient choice.

"As consumers of health care, individual Americans and their families should be able to make their own choices about health care protection. We propose

to assist them in so doing through tax and financial incentives. These could enable them to choose their own health coverage, including protection from the catastrophic costs of major long-term illness, without compulsory regimentation.

"Americans should be protected against financial disaster brought on by medical expense. We recognize both the need to provide assistance in many cases and the responsibility of citizens to provide for their own needs. By using tax incentives and reforming federal medical assistance programs, government and the private sector can jointly develop compassionate and innovative means to provide financial relief when it is most needed.

"We endorse alternatives to institutional care. Not only is it costly but it also separates individuals from the supportive environment of family and friends. This is especially important for the elderly and those requiring long-term care. We advocate the reform of Medicare to encourage home-base care whenever feasible. In addition, we encourage the development of innovative alternate health care deliv-

continued on page 522



Michigan Democrats discuss health care

"The Michigan Democratic Party has long been committed to the concepts of dignity and fairness for all citizens. It has demonstrated this commitment through its Democratic legislators in the State Legislature. The Michigan Democratic Party realizes all that must be accomplished in securing human rights, as well as sound and humane social welfare programs, has not come to pass. For this reason, we renew our commitment to these goals so that all of our citizens can live a decent life with equity and dignity.

Health Education

"Comprehensive health education, emphasizing preventive medicine, is a necessity in our society. Such a program would require health education from kindergarten through college, plus programs within extension agencies and enrichment programs. Topics should include, but not be limited to, nutrition, prenatal care, physical fitness, geriatrics, family planning education, and environmental impacts including healthful living and working conditions.

Mental health

"The Michigan Democratic Party supports the concept of the right of a mentally disabled individual to receive treatment in the least restrictive environment, and will strive to continue the development of sufficient community resources to treat individuals in or near their homes.

"We support the movement to develop alternatives to institutional care in community settings, commensurate with the mentally disabled individual's right to appropriate treatment without segregation from the mainstream of life. We further recognize the need to assist employees displaced from their institutional jobs by providing a priority for them in jobs developed in the community, and by assuring that benefits will not be lost due to transfer.

We are concerned that efforts by the State Department of Mental Health to excessively control community mental health programs often lead to massive amounts of paperwork and delay, and have little impact on improving services. Within the parameters of legislation, community mental health programs should be left free to deliver the services necessary to their communities. Therefore, the Michigan Democratic Party supports the need for community-based mental health services to be controlled and operated at the local level, within necessary monitoring and quality-assurance standards required by the state.

Human services delivery system

"Under the Milliken Administration, many urgent family and social problems have not been addressed. Executive leadership in this area is long overdue, and the citizens of Michigan deserve better.

"The Michigan Democratic Party has always been committed to providing our citizens with assistance to meet various needs. We must now dedicate ourselves to the development of a more effective and humane system of delivering needed services.

"This human services delivery system must maintain and protect the basic dignity and rights of those whose circum-

continued on page 522

Michigan's party leaders speak:



Olivia Maynard, chairman, Michigan Democratic Party

Health is essential to the maintenance of the dignity of our citizens. It is simply a basic human right. It follows that government has a role in supplementing the present health care system in order to guarantee the availability of health care to all citizens.

The Michigan Democratic Party takes seriously its commitment to health care issues. Our commitment is reflected in a party platform — which is developed over a two-year period. It is a platform which the party is serious about, and committed to.

We recognize the need for a "continuum of care" which is accessible to all citizens. This includes such alternatives to traditional care as home health care, health education, and preventive medicine. It recognizes that citizens have different needs from prenatal through geriatrics.

A major concern of the Michigan Democratic Party has been the pas-

sage in 1978 of the Nursing Home Reform Act by the Michigan Legislature, and its subsequent lack of implementation. We recognize that nursing homes are an important and necessary part of this continuum; this recognition demands that nursing homes be of high quality and be committed to restoring independence, not fostering dependence.

The Michigan Democratic Party also recognizes that the health care of Michigan residents is irrevocably linked to Blue Cross/Blue Shield of Michigan. Over 5.4 million state residents are directly dependent on Blue Cross coverage, as are 1,000,000 senior citizens who rely on the Blues to administer the Federal Medicare program. Management of Blue Cross has many times been unresponsive to the needs of Michigan residents.

Interestingly enough, in talking to doctors and hospitals across the state, we find that Blue Cross has been unresponsive to their needs also. Bills are paid late, and service policies are adopted without sufficient provider (or consumer) input.

In addition to making Blue Cross responsive to Michigan residents, it is important to recognize the role this organization plays in the delivery of health care to all residents. As a result, we support legislation which would reform the operations of Blue Cross/Blue Shield of Michigan, in-

cluding the establishment of reasonable cost containment goals with provider cooperation.

For the past several years, Democratic leadership in the Michigan legislature has resulted in increased funding and the development of necessary alternatives for residents in need of mental health services. We support the concept of the right of a mentally disabled individual to receive treatment in the least restrictive environment, and the movement to develop alternatives to institutional care in community settings.

We recognize that improvement in the delivery of health care requires the cooperation of both government and providers. Michigan residents have a legitimate concern that quality health care be available to them at affordable costs, and that governmental programs utilize tax dollars wisely and efficiently.

Providers have a professional commitment to quality care, while objecting to unreasonable governmental dictates and excessive paperwork. Both concerns need to be addressed. The Michigan Democratic Party will work to resolve them.

We share a common goal: the provision of quality, affordable health care accessible to all Michigan residents.



Melvin Larsen, chairman, Michigan Republican Party

The health care industry has felt the pressure of public policy-making bodies since the inception of Medicaid and Medicare. Many lawmakers are of the opinion that public funding dictates a necessity to regulate.

During the 70's we saw the issue crystalize into a debate over the need

for the comprehensive national health insurance plan for all Americans. Such a plan, philosophically, would resolve the concerns for "quality of care" and proper funding.

This debate will continue long into the 1980's. It must be recognized, however, that much already has been accomplished by those supporting national health insurance.

For health care providers to have impact on the legislative process — both at the state and national levels — participation in the election process with both financial and human resources is required.

As well as supporting the candidates whose views align with their own, we have the opportunity to

support the political party that best supports our views. We must remember the two-party system is the backbone of the domestic process; parties give direction to candidates and play a support role in individual elections. When investing in a candidate we also should consider investment in the party, to protect the original investment.

Medical professionals no longer can take a hands-off position in elections. Professionals must get involved to protect their future, both at home and at the office.

Democracy is not a spectator sport — it requires participation.

What are the statewide ballot issues?

The following is excerpted, with permission, from the "Ballot Proposals '80," a document prepared by The League of Women Voters of Michigan.

At the general election on Nov. 4, the following statewide ballot proposals will appear on every ballot in every precinct in the state:

Proposal A — The Smith-Bullard Tax Plan to provide property tax relief and shift financing of school operating costs to state income and business property taxes.

Proposal B — A proposal to lower the legal drinking age from 21 to 19 years of age.

Proposal C — The Legislative-Executive Tax Plan to shift some of the burden of the property tax to the state sales tax.

Proposal D — The Tisch Tax Plan to cut property taxes in half and require the state to replace from current state income revenues lost locally.

Proposal E — A proposal to finance construction of new prisons by increasing the income tax one-tenth of one-percent for five years.

Proposal G — A proposal to allow the legislature to pass laws modifying legislators' constitutional immunity from civil arrest and civil prosecution during legislative sessions.

Proposal H — A proposal to change the powers of the lieutenant governor and to provide a process for filling a vacancy in the office of lieutenant governor.

Proposal A — Smith-Bullard Tax Plan

Intent

The intent of this proposal is to amend the constitution to establish a statewide system of financing elementary and secondary school operations that is not primarily dependent on the local residential property tax, and which would provide equal and quality educational opportunity for all students in the state.

What is proposed

This proposal would place new limits on property tax millage allocations to the counties, townships, community colleges, vocational education and intermediate school districts which would total 13 mills (Presently it is 15 mills). With a vote of the people this could be raised by 11.5 mills. Thus the total property tax millage will not exceed 24.5 mills on residences and family-owned and operated farms. (City and charter township millage is not affected.) The result of this limitation is the removal of the operational millage for schools from the local property tax except for the extra voted millage (or an equivalent income tax) for enrichment programs for community colleges, vocational education, special education and intermediate school districts.

Along with the new limits, 65-year old retirees will be exempt from paying taxes on the first \$25,000 assessed valuation on their homes. This figure will be adjusted annually according to the fluctuation of the Consumer Price Index.

There will be a phase-in period of five years in which there will be no revenue loss to any school district. Replacement of revenues lost to local governments by the property tax reduction and senior citizen exemptions will come from the state. A specific tax plan is left to the legislature, but sponsors expect that major replacement funds will come from an increase of 1.5 to 2.0 percent in the personal income tax, bringing the tax up to 6.1 percent — 6.6 percent (from the present 4.6 percent). A statewide property tax of no more than 30.5 mills on all commercial, development and industrial property is authorized to permit this tax base to be shared for the benefit of all students in the state.

Local control of all programs, services and personnel would be provided Constitutionally rather than by custom or law.

The local millage rollback required by that spending limit (when assessed valuation grows faster than the General Price Level) will be changed to refer to a rollback as to class of property (e.g., agriculture, residential, commercial, industrial, development). The Constitutional rollback now affects only the total property assessment of a unit of government, or assessments of all classes taken together.

The question for voters

Should the present funding of K-12 education be replaced with a statewide financing system that would derive its principal revenue from a statewide tax on commercial, industrial and development property and an increase in the state income tax?

Proposal B — Legal Drinking Age

Intent

To amend the Michigan Constitution to lower the legal drinking age from 21 years to 19 years of age.

What is proposed

The proposal would amend Article IV, Section 40 of the Michigan Constitution to set the legal drinking age at 19 instead of 21 years of age.

The question for the voters

Should the legal age for drinking alcoholic beverages in Michigan be 19 instead of 21 years of age?

Proposal C — The Executive-Legislative Tax Shift Proposal

Intent

The purpose of the proposal is to amend the Constitution to provide property tax relief to homeowners and renters while maintaining essential governmental services. This is primarily a "tax shift" plan, shifting some of the burden of the local property tax to the state sales tax.

What is proposed

A. Property Tax Relief.

The first \$7,100 on the state equalized valuation (SEV) of every homestead (owner-occupied residence) would be exempt from property taxes levied for operational

SPECIAL REPORT/Continued

purposes. The exemption would not apply to taxes levied to repay bonds.

The exemption would be in addition to the present "circuit breaker" property tax credit.

B. Other Tax Relief.

The sales or use tax on residential consumers of energy products (e.g., natural gas, fuel oil, electricity) would be phased out by January 1, 1985.

C. Replacing Lost Revenues.

The state must reimburse local units of government for revenues lost.

The sales and use tax rates would be increased from 4 percent to 5.5 percent to replace revenues lost because of property

tax relief and utility sales tax phase-out.

The additional 1½ cents per dollar sales tax would be earmarked for this replacement.

D. Other Tax Changes.

Lottery revenues would be earmarked for school aid.

The counter-cyclical Budget and Economic Stabilization Fund ("rainy day" fund) would be written into the Constitution.

Assessment of agricultural and forestry property on the basis of use value instead of market value would be permitted.

Some adjustments to the 1978 tax limitation amendment would be made relating to the computation of state spend-

ing requirements and the fixed portion of revenues which are returned to local government.

E. About Taxing Powers.

The proposal would specify that taxing powers are reserved for the state and local units of government deriving taxing powers from the state.

The question for the voters

Should the state grant a measure of property tax relief in addition to the present "circuit breaker" tax credit on owner-occupied homesteads and make up most of the lost revenues with an increase in the sales tax from 4 percent to 5.5 percent?

Proposal D — The "Tisch" Tax Cut Proposal

Intent

The intent of this proposal is to amend the constitution to cut residential property taxes by one-half and to require the state to reimburse local governments for the revenues they will lose. This must be done from current state revenues, thus reducing state services. The proposal also seeks to limit the taxing and appropriations powers of the Michigan Legislature.

What is proposed

A. Cuts in property tax assessments:

1. By using 1978 assessments as the base;

2. By cutting those assessments in half through reducing the maximum percentage of true cash value at which proper-

ty can be assessed from 50 percent to 25 percent;

3. By limiting yearly growth in residential and agricultural assessments to 2 percent.

B. Removal of almost all property tax exemptions now provided by law except for churches and schools.

C. Additional tax exemptions:

1. No person over 62 would pay school millage;

2. No property taxes at all for those with taxable incomes under \$5,000 a year;

3. 50 percent exemption from property taxes for those with taxable incomes of \$5,000 to \$10,000.

D. A requirement for the state to reimburse local governments, including school districts, for revenues lost due to the cut in assessments.

E. Limits on the power of the legislature to tax:

1. By requiring it to submit proposals

for new taxes (defined as including any fee, levy, user charge, special assessment, license, permit, weight or volume tax) or increases in existing taxes to a vote of the people. A 60 percent vote is required for approval.

2. By requiring a 4/5 vote of the legislature to change any existing tax credit, exemption, or rebate or to reduce school aid payments.

The questions for the voters

1. Should the Michigan Constitution mandate a cut in local property taxes by one-half and require the state to reimburse local governments for the resulting revenue loss by cutting state services by a corresponding amount?

2. Should the Legislature's power to tax be limited by high voting requirements and mandated referenda?

Proposal E — Temporary Increase in Income Tax for Prison Construction

Intent

The purpose of the proposal is to obtain voter approval for a law passed by the Michigan Legislature in July, 1980, which would increase the rate of the income tax in Michigan by one-tenth of one percent for a period of five years and earmark the additional revenues to build or renovate prison facilities to alleviate overcrowded conditions.

What is proposed

Between January 1, 1981 and December 31, 1985 the rate of the income tax would be increased to 4.7 percent. On January 1, 1986 it would return to its current rate.

The revenue raised by the additional one-tenth of one percent tax would be appropriated to the Corrections Department and would be used to pay for:

a) Demolition of the state reformatory at Ionia by the end of 1990;

b) Construction of 4 new regional facilities;

c) Preventive programs in local community;

d) "Other state and local correctional purposes."

The question for the voters

Shall the people of Michigan approve an increase in the income tax from 4.6 percent to 4.7 percent for a period of 5 years for the purposes of building new correctional facilities and renovating others to meet modern corrections standards?

Proposal G

A proposal to allow the legislature to pass laws relating to their constitutional exemption from civil arrest during the legislative sessions.

Intent

To amend the Constitution to allow the Legislature to change by statute the provision of immunity from civil arrest and civil process which is currently

granted to members of the Michigan Legislature.

What is proposed

To add to present constitutional language the phrase "Except as provided by law"; Article 4, section 11 would then read:

"Except as provided by law, senators and representatives shall be privileged from civil arrest and civil process during sessions of the legislature and for five

days next before the commencement and after the termination thereof. They shall not be questioned in any other place for any speech in either house."

The question for the voters

Should the Legislature be allowed to provide for changes in the legislative immunity from civil arrest and civil process currently provided in the Constitution?

continued on page 522

This is MDPAC's busiest season

By Kevin A. Kelly, MSMS staff

GENERAL ELECTION

To the Qualified Electors:

NOTICE IS HEREBY GIVEN, That a General
Election will be held

HOUSE OF REPRESENTATIVES
LANSING, MICHIGAN



September 15, 1980

Dear Doctor Payne, Chairman, Michigan Doctors Political Action Committee:

My campaign needs your help - and it needs it NOW if we are to set the stage for the November elections. As you know, a successful campaign takes many volunteers and dollars. . . please contact me soon. I will be happy to discuss my candidacy with you, your staff, and the MDPAC Board of Directors.

MICHIGAN DOCTORS
POLITICAL ACTION COMMITTEE
BOX 769 EAST LANSING
MICHIGAN 48823

October 2, 1980

Dear Representative _____:

The Board of Directors of the Michigan Doctors Political Action Committee met on August 14, and on the advice of our Candidate Selection Committee, approved a contribution to your campaign. . .

HOUSE OF REPRESENTATIVES
LANSING, MICHIGAN



October 6, 1980

Dear Doctor Payne, Chairman, MDPAC:

I would like to thank MDPAC for your financial support of my campaign. It is a pleasure to count you among my supporters, and I am indeed grateful for this vote of confidence. I would hope that my efforts in the Legislature will continue to meet your approval. I look forward to working with you and your membership for the next two years.

Representative _____

It is a political fact of life that it takes a tremendous commitment of human and financial resources to run a successful political campaign.

Political campaigns are expensive. All members of the legislature have a primary interest in being re-elected and it is not unusual for a candidate for the Michigan House of Representatives to spend from \$25,000 to \$50,000 on a campaign.

With this in mind, it is easy to see why it is a candidate's first priority is to raise campaign contributions, and why a candidate may possess a long memory for those individuals and groups who give active support.

MDPAC is an integral part of the MSMS legislative commitment to be an aggressive and effective participant in the political process. MDPAC campaign contributions are made through personal physician contacts with candidates who are sensitive and willing to respond to professional concerns of every practicing physician today.

The illustrations on this page articulate MDPAC's extensive participation and influence in the expanding arena of "electoral cash-flow politics." MDPAC contributions are readily convertible political resources that provide a coordinated means for the medical profession to influence elections and the eventual composition of the state and federal legislatures.

Two benefits

All physicians are encouraged to channel some of their political contributions through MDPAC for two reasons. The first is the power of statewide or "federated" giving. "Federated contributions through MDPAC give physicians an opportunity to affect legislative races across the state.

Second, MSMS legislative efforts "downtown" at the Capitol are enhanced. Office-seekers appreciate the fact that MDPAC contributions represent a large "precinct" of politically concerned and motivated physicians as well as the overall goals of MSMS.

On Nov. 4, the Michigan elector-

SPECIAL REPORT/Continued

ate will select 110 members of the Michigan House of Representatives, 19 Congressmen and two Michigan State Supreme Court Justices. Candidates elected this year will play a crucial role in what will be perhaps the most important statewide political decision of 1980 . . . legislative reapportionment. The legislative dis-

BALLOT PROPOSALS/continued

Proposal H

A proposal to change the powers of the Lieutenant Governor and to provide a process for filling a vacancy in the office of Lieutenant Governor.

Intent

The purpose of the proposal is to amend the Constitution to change the power of the lieutenant governor by removing the lieutenant governor as presiding officer of the Senate, and to provide that in the case of a vacancy in this office, the governor shall nominate someone to fill the vacancy, the nomination to be sub-

ject to confirmation by majority vote of both houses of the legislature.

MDPAC is partisan to the medical profession's principles, not to political parties'.

This year 101 out of 110 state house incumbents are running for re-election. The MDPAC Board of Trustees has paid particular attention to the nine "open seats" (no incum-

ment) as an opportunity for "long term political investment" in a qualified candidate. Open seats provide the greatest opportunity to change the legislature, as better than 90 percent of State House incumbents are returned to office.

The MDPAC Board further categorizes legislative races into "target seats" (incumbent is unacceptable to the medical community and a qualified candidate is seeking office); "seats to save" (seats in which, given known voter statistics an incumbent friendly to medicine could come under attack) and "positive access seats" ("safe races" where individuals are responsive to the MSMS legislative efforts).

Recognizing that early money is a prerequisite for success in many campaigns, MDPAC contributed heartily to the campaigns of many candidates prior to the Aug. 5 primaries. MDPAC also began to work early on its general election recommendations, allowing early contributions to many candidates' "home stretch to the voting booths."

MDPAC educates

MDPAC educates

Political education is a continuing function of MDPAC. This year MDPAC and the MSMS Department of Government Relations are sponsoring Richard Scammon of the Elections Research Center, Washington, DC and Senator Carl Levin at the MSMS Public Affairs Leadership Conference on Oct. 30, just five days before the general election (see page 554). MDPAC will also be publishing an election update newsletter in late October.

Campaign contributions through MDPAC enable a candidate to be a strong competitor in the political marketplace up until the morning of the election, when the political dialogue of the summer ends, and the political choices of the autumn must be made.

Michigan's 12,000 voting physicians and their families constitute a significant political entity — if they do not allow the voting booths to be silent in recording the choices of medicine.

In closing, MDPAC makes its strongest bipartisan recommendation: VOTE! And remember, some of the least admirable of your political neighbors hope you stay home.

REPUBLICAN PLATFORM/continued

ery systems and other out-patient services at the local level.

"We must maintain our commitment to the aged and to the poor by providing quality care through Medicare and Medicaid. These programs need the careful, detailed reevaluation they have never received from the Democrats, who have characteristically neglected their financial stability. We believe that the needs of those who depend upon these programs, particularly the elderly, can be better served, especially when a Republican Administration cracks down on fraud and abuse so that program monies can be directed toward those truly in need. In the case of Medicaid, we will aid the states in restoring its financial integrity and its local direction.

"We welcome the long-overdue em-

phasis on preventive health care and physical fitness that is making Americans more aware than ever of their personal responsibility for good health. Today's enthusiasm and emphasis on staying well holds the promise of dramatically improved health and well-being in the decades ahead. Additionally, health professionals, as well as individuals, have long recognized that preventing illness or injury is much less expensive than treating it. Therefore, preventive medicine combined with good personal health habits and health education, can make a major impact on the cost of health care. Employers and employees, unions and business associations, families, schools, and neighborhood groups all have important parts in what is becoming a national crusade for better living."

DEMOCRATIC PLATFORM/continued

stances require the use of such services, while at the same time maintaining a degree of internal control which guarantees that services are not abused by either the providers or the recipients.

"To assure a coordinated delivery of these services, we call upon the Legislature to develop a plan which meets these goals and removes the bureaucratic obstacles that negate benefits to those in need. For example, a clarification is needed of the fragmented programs and grants for social services by the Department of Social Services and the Department of Men-

tal Health. We urge the elimination of those administrative complexities within the present human services system that are the cause of fraud, inequity and mismanagement and which waste tax dollars collected for legitimate needs.

"We urge the Legislature to seek input from various components of our citizenry while developing such a reconstruction of the human services delivery system. This should include, but not be limited to, users and potential users of the services, community resource centers and professional providers of the services."

The primary beneficiaries of ORAL HYDERGINE[®] TABLETS, 1 mg (1 tab t.i.d.)

Each 1 mg Hydergine tablet contains dihydroergocornine mesylate 0.333 mg, dihydroergocristine mesylate 0.333 mg, and dihydroergocryptine (dihydro-alpha-ergocryptine and dihydro-beta-ergocryptine in the proportion of 2:1) mesylate 0.333 mg, representing a total of 1 mg.

They're in their late sixties, the beneficiaries of more liberal retirement laws and more enlightened attitudes toward the elderly. They're leading socially productive lives. But recently, without any clear cause, they had each begun to experience mild episodes of symptoms such as confusion, mood-depression, and dizziness. Their ability to function could have been jeopardized. That's when they became the beneficiaries of oral Hydergine therapy.



The still-functioning geriatric can benefit from Hydergine treatment

It is quite common for cognitive and emotional symptoms of deterioration to manifest gradually in the elderly. During this early stage, such symptoms are mild and more amenable to treatment. It is at this stage that Hydergine therapy has proved most effective. Patients tend to respond better, and with symptoms effectively relieved—or at least their progression retarded—the ability to function can be maintained.

Oral Hydergine tablets promote better patient compliance

Compared with the sublingual form, dosage administration is easier, with less need for supervision.

Contraindications: Hypersensitivity to the drug.

Precautions: Because the target symptoms are of unknown etiology, careful diagnosis should be attempted before prescribing Hydergine tablets and sublingual tablets.

Adverse Reactions: Serious side effects have not been found. Some sublingual irritation, transient nausea, and gastric disturbances have been reported. Hydergine tablets and sublingual tablets do not possess the vasoconstrictor properties of natural ergot alkaloids.

Dosage and Administration: 1 mg three times daily. Alleviation of symptoms is usually gradual and results may not be observed for 3–4 weeks.

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Before prescribing, see package insert for full product information.

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MSMS jail health project provides unique training

By David Schut, MSMS staff



Training session participants included, from left, Robert Hope, medical officer, Oakland County Sheriff's Department; Lois Storrer, RN, Shiawassee County Health Department, and Margo Wiley, RN, Midland County Sheriff's Department.

Seventeen persons have committed suicide in Michigan jails to date this year, which equals the year-end total of similar deaths in 1979.

Addressing this and other serious problem areas, the MSMS Jails Project, in cooperation with the Michigan Department of Corrections, sponsored a health care training seminar over the week of July 21-25.

Fourteen representatives from sheriffs' departments in Cass, Ingham, Kalamazoo, Kent, Midland, Oakland, Saginaw and Shiawassee counties successfully completed the recent AMA Instructor's Training Session. This 'train-the-trainer' course was developed through close work between the MSMS Jails Project coordinator and Donald Walter, supervisor of training for the Michigan Department of Corrections.

Mr. Schut is MSMS Jails Project coordinator.

These newly qualified instructors will now provide instruction to their own jail staffs in areas such as mental illness and suicide prevention, chemical dependency, symptoms of common illnesses, and emergency situations.

First in nation

This approach is a first-of-its-kind attempt to rapidly disseminate health education to county jail staffs, who typically have no internal mechanism for providing such training on their own. As such, these trainers are the first "graduates" of any such course nationally, and the success of this program will be of interest not only to Michigan corrections personnel, but others around the country as well.

The focus of the week-long course was to improve the teaching skills of the individual participants, whose backgrounds ranged widely from registered nursing degrees to no



Donald Walter, Michigan Department of Corrections, leads MSMS jail health training session.

medical training whatsoever. Each student presented a unit of the 16-hour course to the rest of the participants and was given feedback, after first observing a course instructor present the material.

The course instructors were Donald Walter, who has presented the material in training sessions held in Mississippi, Indiana, and across the state, and Sara Klein, RN, jails project coordinator for the Indiana State Medical Association. Lois Storrer, RN, a public health nurse who also functions as a jail nurse, also provided instruction.

In addition to developing the health training course, other cooperative efforts with the Department of Corrections have been equally successful. Working with MDC Jail Services Administrator Jeffrey Eubank, changes have been made in the proposed jail regulations scheduled for

continued on page 526



"EVERY AGE HAS ITS PLEASURES,
ITS STYLE OF WIT, AND ITS OWN WAYS."

—from *The Art of Poetry* (1674) by Nicholas Boileau-Despréaux

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MSMS group health insurance premiums holding the line against inflation

MSMS members' group health insurance premiums rose just 3.1 percent in 1979, and have risen just 5.8 percent in 1980, although inflation has increased costs significantly more, in general.

The reason for the small size of the increase is the MSMS members' and dependents' average hospital stay in 1979 was 6.65 days, which is somewhat lower than the average for Michigan of 6.9 days.

It would appear that we, in fact, underuse the hospitals compared to

the general public.

During 1979, physician subscribers to the MSMS group insurance program with Blue Cross Blue Shield of Michigan cost their insurance company \$6,034,198.36 in benefits. Of that amount, \$4,261,821.04 went for services provided in facilities, while \$1,772,357.32 went for professional services.

Physicians and their dependents billed BCBSM for 11,718 facility services, and 9,910 professional services.

Of the \$4,261,821.04 in facility benefits, physicians billed for \$1,501,530.53 of the \$4,261,821.04 in facility benefits, while their dependents billed for the remainder.

The following amounts were paid facilities for physicians' and dependents' medical care:

Surgery	\$1,980,883.79
Maternity	\$ 274,489.31
Diagnostic X-ray	\$ 120,676.68
Outpatient	
medical care	\$ 24,172.16
Lab-Pathology	\$ 198,612.56
Medical emergency	\$ 65,794.87
Psychiatric care	\$ 297,596.89
Physical therapy	\$ 37,537.39
Therapeutic X-ray	\$ 20,688.45

JAILS PROJECT/Continued

legislative action this fall which allow for more flexibility in the provision of health services to inmates.

With the trend toward more class action and civil liability suits stemming from alleged unconstitutional conditions of confinement, the need for expertise and assistance in the management of jail health services is more pronounced than ever before. Functioning as an information clearinghouse, the Jails Project has worked closely with the Department of Corrections to monitor other states' efforts in these areas.

One-third of jails

To date, 30 of Michigan's 81 county jails have received technical assistance in setting up policies and procedures, identifying physicians in the community willing to provide services to the jail and directing jails to additional resources. Often the rural jail needs only a few hours per week of physician time to insure adequate health care for its inmates, for the program encourages the vigorous use of support staff such as physician extenders. Physicians who have an interest in this area are urged to contact the author at MSMS headquarters.

Other developments within the Project include the recent completion of the revised Michigan reference guide and practical workbook, a document used by jail administrative staff which suggests policies and

procedures for use in working towards compliance with the AMA Standards for Health Services in Jails. The guide is a self-help tool which assists in setting up well-documented health services.

Michigan jails continue to work towards AMA accreditation of their health services. Currently, jails in Kent, Oakland, Saginaw, Berrien and Shiawassee are being reviewed by the AMA's Advisory Group and the outcome of their quest for accreditation is expected to be known soon.

Michigan sheriffs continue to be enthusiastic about the Jails Project, evidenced by the excellent turnout for the recent Instructor's Training course. In these times of strained county budgets and limited overtime finances, Michigan sheriffs are to be commended for putting high priority on health education for their jail staffs.

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WHEN ANXIETY AND TENSION MAGNIFY PAIN

IN MUSCULOSKELETAL DISEASE*



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EQUAGESIC[®]

(meprobamate and ethoheptazine citrate with aspirin) Wyeth

EQUAGESIC—Abbreviated Summary

INDICATIONS: Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:

"Possibly" effective for the treatment of pain accompanied by tension and/or anxiety in patients with musculoskeletal disease or tension headache. Final classification of the less-than-effective indications requires further investigation.

The effectiveness of Equagesic in long-term use, i.e. more than four months, has not been assessed by systematic clinical studies. The physician should periodically reassess usefulness of the drug for the individual patient.

CONTRAINDICATIONS: Equagesic should not be given to individuals with a history of sensitivity or severe intolerance to aspirin, meprobamate, or ethoheptazine citrate.

WARNINGS: Careful supervision of dose and amounts prescribed for patients is advised, especially with those patients with known propensity for taking excessive quantities of drugs. Excessive and prolonged use in susceptible persons, e.g. alcoholics, former addicts, and other severe psychoneurotics, has been reported to result in dependence on or habituation to the drug. Where excessive dosage has continued for weeks or months, dosage should be reduced gradually rather than abruptly stopped, since withdrawal of a "crutch" may precipitate withdrawal reaction of greater proportions than that for which the drug was originally prescribed. Abrupt discontinuance of doses in excess of the recommended dose has resulted in some cases in the occurrence of epileptiform seizures.

Special care should be taken to warn patients taking meprobamate that tolerance to alcohol may be lowered with resultant slowing of reaction time and impairment of judgement and coordination.

USAGE IN PREGNANCY AND LACTATION: An increased risk of congenital malformations associated with the use of minor tranquilizers (meprobamate, chlorid-

azapoxide, and diazepam) during the first trimester of pregnancy has been suggested in several studies. Because use of these drugs is rarely a matter of urgency, their use during this period should almost always be avoided. The possibility that a woman of child-bearing potential may be pregnant at the time of institution of therapy should be considered. Patients should be advised that if they become pregnant during therapy or intend to become pregnant they should communicate with their physicians about the desirability of discontinuing the drug.

Meprobamate passes the placental barrier. It is present both in umbilical-cord blood and in near maternal plasma levels and in breast milk of lactating mothers at concentrations two to four times that of maternal plasma. When use of meprobamate is contemplated in breast-feeding patients, the drug's higher concentrations in breast milk as compared to maternal plasma levels should be considered.

Preparations containing aspirin should be kept out of the reach of children. Equagesic is not recommended for patients 12 years of age and under.

PRECAUTIONS: Should drowsiness, ataxia, or visual disturbance occur, the dose should be reduced. If symptoms continue, patients should not operate a motor vehicle or any dangerous machinery.

Suicidal attempts with meprobamate have resulted in coma, shock, vasomotor and respiratory collapse, and anuria. Very few suicidal attempts were fatal, although some patients ingested very large amounts of the drug (20 to 40 gm). These doses are much greater than recommended. The drug should be given cautiously and in small amounts to patients who have suicidal tendencies. In cases where excessive doses have been taken, sleep ensues rapidly and blood pressure, pulse, and respiratory rates are reduced to basal levels. Hyperventilation has been reported occasionally. Any drug remaining in the stomach should be removed and symptomatic treatment given. Should respiration become very shallow and slow, CNS stimulants, e.g., caffeine, Metrazol, or am-

phetamine, may be cautiously administered. If severe hypotension develops, pressor amines should be used parenterally to restore blood pressure to normal levels.

ADVERSE REACTIONS: A small percentage of patients may experience nausea with or without vomiting and epigastric distress. Dizziness occurs rarely when meprobamate and ethoheptazine citrate with aspirin is administered in recommended dosage. The meprobamate may cause drowsiness but, as a rule, this disappears as therapy is continued. Should drowsiness persist and be associated with ataxia, this symptom can usually be controlled by decreasing the dose, but occasionally it may be desirable to administer central stimulants such as amphetamine or mephentermine sulfate concomitantly to control drowsiness.

A clearly related side effect to the administration of meprobamate is the rare occurrence of allergic or idiosyncratic reactions. This response develops, as a rule, in patients who have had only 1-4 doses of meprobamate and have not had a previous contact with the drug. Previous history of allergy may or may not be related to the incidence of reactions. Mild reactions are characterized by an itchy urticarial or erythematous maculopapular rash which may be generalized or confined to the groin. Acute nonthrombocytopenic purpura with cutaneous petechiae, ecchymoses, peripheral edema, and fever have also been reported.

More severe cases, observed only very rarely, may also have other allergic responses including fever, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anaphylaxis, stomatitis and proctitis (1 case), and hyperthermia. Treatment should be symptomatic such as administration of epinephrine, antihistamine, and possibly hydrocortisone. Meprobamate should be stopped and reinstitution of therapy should not be attempted.

Rare cases have been reported where patients receiving meprobamate suffered from aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis, and hemolytic anemia. In nearly every instance reported, other toxic agents known to have caused these conditions have been associated with meprobamate. A few cases of leukopenia during

continuous administration of meprobamate are reported, most of these returned to normal without discontinuation of the drug.

Impairment of accommodation and visual acuity has been reported rarely.

OVERDOSE: Two instances of accidental or intentional significant overdose with ethoheptazine citrate combined with aspirin have been reported. These were accompanied by symptoms of CNS depression including drowsiness and light-headedness with uneventful recovery. However, on the basis of pharmacological data, it may be anticipated that CNS stimulation could occur. Other anticipated symptoms would include nausea and vomiting. Appropriate therapy of signs and symptoms as they appear is the only recommendation possible at this time. Overdosage with ethoheptazine combined with aspirin would probably produce the usual symptoms and signs of salicylate intoxication. Observation and treatment should include induced vomiting or gastric lavage, specific parenteral electrolyte therapy for ketoacidosis and dehydration, watching for evidence of hemorrhagic manifestations due to hypoprothrombinemia which, if it occurs, usually requires whole-blood transfusions.

DESCRIPTION: Each Equagesic tablet contains 150 mg meprobamate, 75 mg ethoheptazine citrate and 250 mg aspirin.

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*This drug has been evaluated as possibly effective for this indication.

Wyeth Laboratories
Philadelphia, Pa. 19101



TM

FOR MODERATE PAIN

A therapeutic dose
of acetaminophen
in one tablet

A therapeutic dose
of two complementary
analgesics

The convenience and
economy of a
dosage schedule of
one tablet, every four
hours as needed



WHY NOT WYGESIC®

(65 mg propoxyphene HCl and 650 mg acetaminophen) Wyeth

WYGESIC—Abbreviated Summary

INDICATION: For the relief of mild-to-moderate pain.

CONTRAINDICATION: Hypersensitivity to propoxyphene or to acetaminophen.

WARNINGS: CNS ADDITIVE EFFECTS AND OVERDOSAGE: Propoxyphene in combination with alcohol, tranquilizers, sedative-hypnotics, or other CNS depressants has an additive depressant effect. Patients taking this drug should be advised of the additive effect and warned not to exceed the dosage recommended. Toxic effects and fatalities have occurred following overdoses of propoxyphene alone or in combination with other CNS depressants. Most of these patients had histories of emotional disturbances or suicidal ideation or attempts, as well as misuse of tranquilizers, alcohol, or other CNS-active drugs. Caution should be exercised in prescribing large amounts of propoxyphene for such patients (see **Management of Overdosage**).

DRUG DEPENDENCE: Propoxyphene can produce drug dependence characterized by psychic dependence and less frequently, physical dependence and tolerance. It will only partially suppress the withdrawal syndrome in individuals physically dependent on morphine or other narcotics. The abuse liability of propoxyphene is qualitatively similar to codeine's although quantitatively less, and propoxyphene should be prescribed with the same degree of caution appropriate to the use of codeine.

USAGE IN AMBULATORY PATIENTS: Propoxyphene may impair the mental and/or physical abilities required for potentially hazardous tasks, e.g. driving a car or operating machinery. Patients should be cautioned accordingly.

USAGE IN PREGNANCY: Safe use in pregnancy has not been established relative to possible adverse effects on fetal development. **INSTANCES OF WITHDRAWAL SYMPTOMS IN THE NEONATE HAVE BEEN REPORTED FOLLOWING USAGE DURING PREGNANCY.** Therefore, propoxyphene should not be used in pregnant women unless, in the

judgement of the physician, the potential benefits outweigh the possible hazards.

USAGE IN CHILDREN: Propoxyphene is not recommended for children because documented clinical experience has been insufficient to establish safety and a suitable dosage regimen in the pediatric group.

PRECAUTIONS: Confusion, anxiety, and tremors have been reported in a few patients receiving propoxyphene concomitantly with orphenadrine. The CNS depressant effect of propoxyphene may be additive with other CNS depressants, including alcohol.

ADVERSE REACTIONS: The most frequent adverse reactions are dizziness, sedation, nausea, and vomiting. These seem more prominent in ambulatory than in nonambulatory patients; some of these reactions may be alleviated if the patient lies down.

Other adverse reactions include constipation, abdominal pain, skin rashes, light-headedness, headache, weakness, euphoria, dysphoria, and minor visual disturbances. The chronic ingestion of propoxyphene in doses over 800 mg per day has caused toxic psychoses and convulsions. Cases of liver dysfunction have been reported.

DRUG INTERACTIONS: Propoxyphene in combination with alcohol, tranquilizers, sedative-hypnotics, and other CNS depressants has an additive depressant effect. Patients taking this drug should be advised of the additive effect and warned not to exceed the dosage recommended. (see **Warnings**) Confusion, anxiety, and tremors have been reported in a few patients receiving propoxyphene concomitantly with orphenadrine.

MANAGEMENT OF OVERDOSAGE: SYMPTOMS The manifestations of serious overdosage with propoxyphene are similar to those of narcotic overdosage and include respiratory depression (a decrease in respiratory rate and/or tidal volume, Cheyne-Stokes respiration, cyanosis), extreme somnolence progressing to stupor or coma, pupillary constriction, and circulatory collapse. In addition to these characteristics, which are reversed by narcotic antago-

nists such as naloxone, there may be other effects. Overdoses of propoxyphene can cause delay of cardiac conduction as well as focal or generalized convulsions, a prominent feature in most cases of severe poisoning. Cardiac arrhythmias and pulmonary edema have occasionally been reported, and apnea, cardiac arrest, and death have occurred.

Symptoms of massive overdosage with acetaminophen may include nausea, vomiting, anorexia, and abdominal pain, beginning shortly after ingestion and lasting for 12 to 24 hours. However, early recognition may be difficult since early symptoms may be mild and nonspecific. Evidence of liver damage is usually delayed. After the initial symptoms, the patient may feel less ill; however, laboratory determinations are likely to show a rapid rise in liver enzymes and bilirubin. In case of serious hepatotoxicity, jaundice, coagulation defects, hypoglycemia, encephalopathy, coma, and death may follow. Renal failure due to tubular necrosis, and myocardopathy, have also been reported.

Ingestion of 10 grams or more of acetaminophen may produce hepatotoxicity. A 13-gram dose has reportedly been fatal.

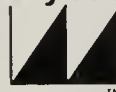
TREATMENT: Primary attention should be given to the reestablishment of adequate respiratory exchange through provision of a patent airway and institution of assisted or controlled ventilation. The narcotic antagonists, naloxone, nalorphine, and levallorphan, are specific antidotes against the respiratory depression produced by propoxyphene. An appropriate dose of one of these antagonists should be administered, preferably IV, simultaneously with efforts at respiratory resuscitation and the antagonist should be repeated as necessary until the patient's condition remains satisfactory. In addition to a narcotic antagonist, the patient may require careful titration with an anticonvulsant to control seizures. Analeptic drugs (e.g. caffeine or amphetamine) should not be used because of their tendency to precipitate convulsions.

Oxygen, IV fluids, vasopressors and other supportive measures should be used as indicated. Gastric lavage may be helpful. Activated charcoal can absorb a significant amount of ingested propoxyphene. Dialysis is of little value in poisoning by propoxyphene alone. Acetaminophen is rapidly absorbed, and efforts to remove the drug from the body should not be delayed. Copious gastric lavage and/or induction of emesis may be indicated. Activated charcoal is probably ineffective unless administered almost immediately after acetaminophen ingestion. Neither forced diuresis nor hemodialysis appears to be effective in removing acetaminophen. Since acetaminophen in overdose may have an antidiuretic effect and may produce renal damage, administration of fluids should be carefully monitored to avoid overload. It has been reported that mercaptamine (cysteine) or other thiol compounds may protect against liver damage if given soon after overdosage (8-10 hours). N-acetylcysteine is under investigation as a less toxic alternative to mercaptamine, which may cause anorexia, nausea, vomiting, and drowsiness. Appropriate literature should be consulted for further information. (JAMA 237:2406-2407, 1977)

Clinical and laboratory evidence of hepatotoxicity may be delayed up to one week. Acetaminophen plasma levels and half-life may be useful in assessing the likelihood of hepatotoxicity. Serial hepatic enzyme determinations are also recommended.

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AAP coming home to Detroit for golden anniversary meeting

By Dwight Angell, special to Michigan Medicine



Harry A. Towsley, MD, FAAP, Ann Arbor, past president of the American Academy of Pediatrics, speaks at AAP Founders' Day celebrations this summer at Children's Hospital of Michigan in Detroit. The AAP was founded 50 years ago at Harper Hospital, directly across the street from Children's Hospital, and is holding its golden anniversary annual meeting in Detroit this month. (AAP photo)

This October the American Academy of Pediatrics is celebrating its Golden Anniversary in Detroit, the founding place of the Academy. There, in 1930, pediatricians established the Academy as "an independent pediatric forum where discussion could be free, intelligent and continuous." Their goal; "the attainment by all children of the Americas of their full potential for physical, emotional and social health."

A year later the Academy held its first Annual Meeting in Atlantic City. Almost 100 pediatricians came to the meeting at the Ambassador Hotel.

This time, pediatricians from across the United States and Canada will come to Detroit's Renaissance Center for the six-day event, Oct. 25 to Oct. 30. The scientific meeting will include 20 seminars, 54 round tables and 68 informal discussion groups.

Unprecedented scope

William Montgomery, MD, a local planner of the convention, claims there has been "more planning for this meeting than for any other convention. It will be the best convention. Because it is the 50th Anniversary, we have put together our finest educational program ever."

Doctor Montgomery is chairman of the department of pediatrics and adolescent medicine at Detroit's Mount Carmel Mercy Hospital. He also is chairman of the Academy's District V, which includes Michigan, Ohio, Indiana and Ontario.

The scope and depth of the six day meeting for pediatricians and their families is unprecedented.

First and foremost are the day-long seminars. They take place on Saturday, Oct. 15 and Wednesday, Oct. 29. Topics to choose include drug use, adolescent health care, pe-

diatric orthopedics, pediatric cardiology, pediatric psychiatry, and allergy and immunology.

The 54 round table discussion groups are half-day sessions, scheduled from Sunday through Thursday. Sessions will be devoted to such topics as sexual abuse, failure to thrive, nuclear medicine, Sudden Infant Death Syndrome and Near Miss, parenting, and care of the chronically ill child. Various committees of the AAP Council on Pediatric Practice will offer round table discussions, with subjects including emergency care, medicaid reform and health resources for rural children.

Among the categories in the plenary sessions are adolescent medicine, pediatric surgery, infectious diseases and neonatology. And after the Monday morning opening address by AAP president Bruce Graham, MD, Robert Good, MD, PhD, president and director of the famed Sloan-Kettering Institute for Cancer Research, will speak on the history of immunology.

The AAP Sections on Allergy and Immunology, Child Development, Adolescent Health, Community Pediatrics, and others will host scientific meetings in conjunction with the Academy sessions. The National Association of Pediatric nurse Associates and Practitioners, the Society for Adolescent Medicine, and the American Association of Pro-Life Pediatricians also will hold sessions at the time of the AAP meeting.

Dignitaries attending

Opening up on Saturday evening will be a session entitled "Saturday Night Live," featuring three of the country's leading pediatricians who will answer any and all questions from the audience. The experience is described as "your no-holds-barred opportunity to stump, stupefy and possibly stultify the experts."

There is, of course, much, much



Unveiling the plaque commemorating the AAP founding 50 years ago are, from left, Doctor Towsley; Edward B. Shaw, MD, FAAP, one of the original founders and an AAP past president, and Robert M. Heavenrich, MD, FAAP, Saginaw, also past AAP president. (AAP photo)

more. There will be technical and scientific exhibits and, upon arriving at the convention, each attendee will receive a complimentary copy of the hardcover book, "American Academy of Pediatrics: The First Fifty Years," written by James G. Hughes. On Tuesday evening, Johnson & Johnson is sponsoring, for the 25th year, a symphony concert exclusively for Academy members.

Opening ceremonies will be on Sunday. More than 75 capped and gowned AAP past presidents, presidents of other pediatric organizations of the US and abroad, national medical organizations, medical specialty societies and other dignitaries will listen to a brief history of the Academy in the two-hour program. Donald Henderson, MD, the featured speaker, is best known as the man who was chiefly responsible for eliminating smallpox. He headed the World Health Organization's global smallpox eradication campaign. During his first year as director of the WHO eradication campaign, an estimated 10 to 15 million smallpox cases occurred and 2,000,000 persons died in more than 40 countries. As of last year, the disease is all but medical history.

Doctor Henderson is presently dean of the Johns Hopkins School of Hygiene and Public Health, a posi-

tion he assumed in 1977.

Another leading speaker at the convention is David Rogers, MD, Monday morning's keynote speaker. He is president of the Robert Wood Johnson Foundation, a post he has held since 1972. The Foundation is a private philanthropy "interested in improving health in the United States." Some of their programs include the Rural Infant Care Program, School Health Services Program and the General Pediatrics Academic Development Program.

Extracurricular activities

On a lighter side of the meeting, there is also a wide variety of activities to choose from.

On Monday evening, comedian Bill Cosby will provide entertainment after the champagne dinner. Cosby, internationally known for his gentle humor on the subject of children, will be made an Honorary Fellow of the Academy.

Activities for the family include a fun run, guided sightseeing trip through the cultural and ethnic areas of Detroit, tours of Greenfield Village and more.

Two new programs for this convention have been added, says Doctor Montgomery. They are a program for adult education and a program for children.

The adult program is not only for the physician but also for the spouse. Some of the topics to choose from are urban growth, the survival of the political parties, history of black families and labor unions.

For the children, there are activities slated for both Monday and Tuesday that include visiting Belle Isle and the Detroit Science Center.

National goals

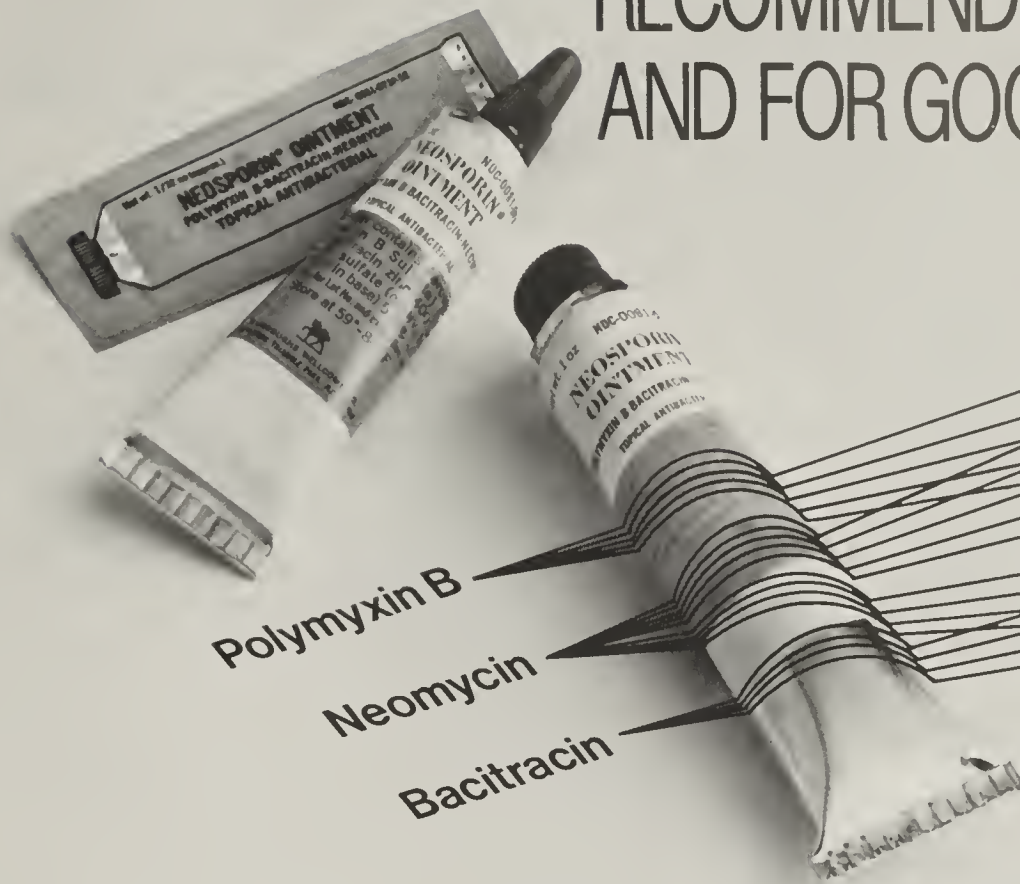
The focus of the Academy's Golden Anniversary is "an agenda for American's Children" which lists 10 National Child Health Goals and provides the guidelines to improve the health and welfare of American's children.

"If children and their physical, intellectual and emotional development are, in fact, a national priority, society must now recognize the commitment needed to attain the Academy's 10 national child health goals and intensify its drive for improvement in child health care," notes Bruce Graham, MD, president of the Academy.

The goals are:

- All children should be wanted and born to healthy mothers.
- All children should be born well.
- All children should be immunized against the preventable infectious diseases for which there are recommended immunization procedures.
- All children should have good nutrition.
- All children should be educated about health and the health care system.
- All children should live in a safe environment.
- All children with chronic handicaps should be able to function at their optimal level.
- All children should live in a family setting with an adequate income to provide basic needs to insure physical, mental and intellectual health.
- All children should live in an environment that is as free as possible from contaminants.
- All adolescents and young people should live in a societal setting that recognizes their special health, personal and social needs.

IT'S HIGHLY
RECOMMENDED...
AND FOR GOOD REASONS



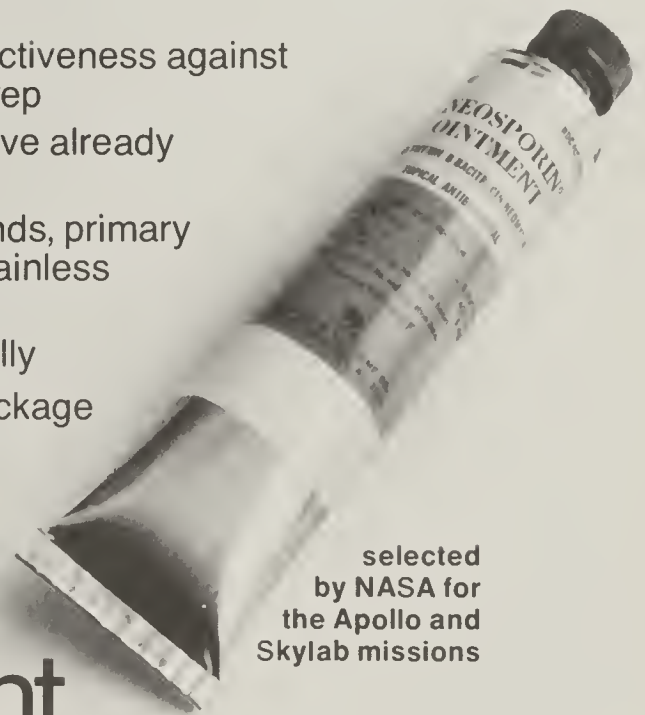
Polymyxin B

Neomycin

Bacitracin

Gram-negative
Pseudomonas
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Aerobacter
Escherichia
Proteus
Gram-positive
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1. provides broad-spectrum, overlapping antibacterial effectiveness against common susceptible pathogens, including staph and strep
2. helps prevent topical infections, and treats those that have already started
3. it's good medicine for abrasions, lacerations, open wounds, primary pyodermas, secondarily infected dermatoses; and it's painless and cosmetically pleasing
4. contains three antibiotics that are rarely used systemically
5. you can recommend it in any of the three convenient package sizes: 1 oz tube, 1/2 oz tube, or the versatile, single-use foil packet



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by NASA for
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Skylab missions

NEOSPORIN[®] Ointment

(polymyxin B-bacitracin-neomycin)

Each gram contains: Aerosporin[®] (Polymyxin B Sulfate) 5,000 units, bacitracin zinc 400 units, neomycin sulfate 5 mg (equivalent to 3.5 mg neomycin base); special white petrolatum qs; in tubes of 1 oz and 1/2 oz and 1/32 oz (approx.) foil packets.

WARNING: Because of the potential hazard of nephrotoxicity and ototoxicity due to neomycin, care should be exercised when using this product in treating extensive burns, trophic ulceration and other extensive conditions where absorption of neomycin is possible. In burns where more than 20 percent of the body surface is affected, especially if the patient has impaired renal function or is receiving other aminoglycoside antibiotics concurrently, not more than one application a day is recommended.

When using neomycin-containing products to control secondary infection in the chronic dermatoses, it should be borne in mind that the skin is more liable to become sensitized to many substances, including neomycin. The manifestation of sensitization to neomycin is usually a low grade reddening with swelling, dry scaling and itching; it may be manifest simply as a failure to heal. During long-term use of neomycin-containing products, periodic examination for such signs is advisable and the patient should be told to discontinue the product if they are observed. These symptoms regress quickly on withdrawing the medication. Neomycin-containing applications should be avoided for that patient thereafter.

PRECAUTIONS: As with other antibacterial preparations,

prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs.

ADVERSE REACTIONS: Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of persons allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section).

Complete literature available on request from Professional Services Dept. PML



Burroughs Wellcome Co.
Research Triangle Park
North Carolina 27709

HEALTH PLANNING UPDATE

By Dennis Paradis, Director
MSMS Physician/HSA Support Center



PSRO role in appropriateness review

In a new development in health planning HSAs are reaching out to PSROs for help.

The HSAs' new function of appropriateness review, which is intended to assess existing institutional services, must, as a part of that responsibility, assess the quality of the care rendered by that service. In many cases, HSA personnel are realizing that quality of care issues only can be assessed by physicians. For this reason, HSAs are turning to PSROs to establish quality of care criteria. These quality of care criteria will be used with utilization criteria developed by the HSA to assess the overall appropriateness of a service.

Societal factors influence hospital use

A study conducted for the federal Department of Health and Human Services has found that cities with distinct ethnic communities have higher hospital-to-population ratios because there are usually several small hospitals to serve these communities. The effort to maintain such hospitals combined with the demographic shift to suburban areas account for some of the "excess" hospital beds. The study concludes that "Social and political dynamics that govern hospital bed supply are much more complex than is acknowledged by current regulation and legislation." The authors suggest that the findings of the study warrant a broadening of the current definition of "need" for hospital services. This study supports similar arguments made by physicians as to why hospital use is higher in the Detroit area.

HSAs immune from antitrust

A July 22 opinion from the federal appeals court in St. Louis, Missouri holds that consumers and providers may work together in implementing the health planning legislation without violating antitrust laws. The court held that Blue Cross of Kansas City may refuse to sign a reimbursement contract with a hospital that did not obtain permission from the HSA for construction. The court acknowledged that the hospital could appeal were it not for the "specific provisions of the National Health Planning and Resources Development Act for voluntary cooperation and assistance of private entities and persons in the community and the health care market."

Tenuate®

(diethylpropion hydrochloride NF)

Tenuate Dospan®

(diethylpropion hydrochloride NF) controlled-release

AVAILABLE ONLY ON PRESCRIPTION

Brief Summary

INDICATION: Tenuate and Tenuate Dospan are indicated in the management of exogenous obesity as a short-term adjunct (a few weeks) in a regimen of weight reduction based on caloric restriction. The limited usefulness of agents of this class should be measured against possible risk factors inherent in their use such as those described below.

CONTRAINDICATIONS: Advanced arteriosclerosis, hyperthyroidism, known hypersensitivity, or idiosyncrasy to the sympathomimetic amines, glaucoma. Agitated states. Patients with a history of drug abuse. During or within 14 days following the administration of monoamine oxidase inhibitors, (hypertensive crises may result).

WARNINGS: If tolerance develops, the recommended dose should not be exceeded in an attempt to increase the effect, rather, the drug should be discontinued. Tenuate may impair the ability of the patient to engage in potentially hazardous activities such as operating machinery or driving a motor vehicle; the patient should therefore be cautioned accordingly. **Drug Dependence:** Tenuate has some chemical and pharmacologic similarities to the amphetamines and other related stimulant drugs that have been extensively abused. There have been reports of subjects becoming psychologically dependent on diethylpropion. The possibility of abuse should be kept in mind when evaluating the desirability of including a drug as part of a weight reduction program. Abuse of amphetamines and related drugs may be associated with varying degrees of psychologic dependence and social dysfunction which, in the case of certain drugs, may be severe. There are reports of patients who have increased the dosage to many times that recommended. Abrupt cessation following prolonged high dosage administration results in extreme fatigue and mental depression; changes are also noted on the sleep EEG. Manifestations of chronic intoxication with anorectic drugs include severe dermatoses, marked insomnia, irritability, hyperactivity, and personality changes. The most severe manifestation of chronic intoxications is psychosis, often clinically indistinguishable from schizophrenia. **Use in Pregnancy:** Although rat and human reproductive studies have not indicated adverse effects, the use of Tenuate by women who are pregnant or may become pregnant requires that the potential benefits be weighed against the potential risks. **Use in Children:** Tenuate is not recommended for use in children under 12 years of age.

PRECAUTIONS: Caution is to be exercised in prescribing Tenuate for patients with hypertension or with symptomatic cardiovascular disease, including arrhythmias. Tenuate should not be administered to patients with severe hypertension. Insulin requirements in diabetes mellitus may be altered in association with the use of Tenuate and the concomitant dietary regimen. Tenuate may decrease the hypotensive effect of guanethidine. The least amount feasible should be prescribed or dispensed at one time in order to minimize the possibility of overdosage. Reports suggest that Tenuate may increase convulsions in some epileptics. Therefore, epileptics receiving Tenuate should be carefully monitored. Titration of dose or discontinuance of Tenuate may be necessary.

ADVERSE REACTIONS: **Cardiovascular:** Palpitation, tachycardia, elevation of blood pressure, precordial pain, arrhythmia. One published report described T-wave changes in the ECG of a healthy young male after ingestion of diethylpropion hydrochloride. **Central Nervous System:** Overstimulation, nervousness, restlessness, dizziness, jitteriness, insomnia, anxiety, euphoria, depression, dysphoria, tremor, dyskinesia, mydriasis, drowsiness, malaise, headache; rarely psychotic episodes at recommended doses. In a few epileptics an increase in convulsive episodes has been reported. **Gastrointestinal:** Dryness of the mouth, unpleasant taste, nausea, vomiting, abdominal discomfort, diarrhea, constipation, other gastrointestinal disturbances. **Allergic:** Urticaria, rash, ecchymosis, erythema. **Endocrine:** Impotence, changes in libido, gynecostasia, menstrual upset. **Hematopoietic System:** Bone marrow depression, agranulocytosis, leukopenia. **Miscellaneous:** A variety of miscellaneous adverse reactions has been reported by physicians. These include complaints such as dyspnea, hair loss, muscle pain, dysuria, increased sweating, and polyuria.

DOSAGE AND ADMINISTRATION: Tenuate (diethylpropion hydrochloride): One 25 mg. tablet three times daily, one hour before meals, and in mid-evening if desired to overcome night hunger. Tenuate Dospan (diethylpropion hydrochloride) controlled-release: One 75 mg. tablet daily, swallowed whole, in mid-morning. Tenuate is not recommended for use in children under 12 years of age.

OVERDOSAGE: Manifestations of acute overdosage include restlessness, tremor, hyperreflexia, rapid respiration, confusion, assaultiveness, hallucinations, panic states. Fatigue and depression usually follow the central stimulation. Cardiovascular effects include arrhythmias, hypertension or hypotension and circulatory collapse. Gastrointestinal symptoms include nausea, vomiting, diarrhea, and abdominal cramps. Overdose of pharmacologically similar compounds has resulted in fatal poisoning, usually terminating in convulsions and coma. Management of acute Tenuate intoxication is largely symptomatic and includes lavage and sedation with a barbiturate. Experience with hemodialysis or peritoneal dialysis is inadequate to permit recommendation in this regard. Intravenous phenolamine (Regitine®) has been suggested on pharmacologic grounds for possible acute, severe hypertension, if this complicates Tenuate overdosage.

Product Information as of April, 1976

MERRELL-NATIONAL LABORATORIES Inc.

Cayey, Puerto Rico 00633

Direct Medical Inquiries to:

MERRELL-NATIONAL LABORATORIES

Division of Richardson-Merrell Inc.

Cincinnati, Ohio 45215, U.S.A.

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References: 1. Citations available on request from Medical Research Department, MERRELL-NATIONAL LABORATORIES, Cincinnati, Ohio 45215. 2. Hoekenga, M.T., O'Dillon [Dillon], R.H., and Leyland, H.M. A comprehensive review of diethylpropion hydrochloride. In: *Central Mechanisms of Anorectic Drugs*, S. Garattini and R. Samanin, Ed., New York, Raven Press, 1978, pp. 391-404.

Merrell

9-4672 (Y957A)

**Overweight may not always be simple...
complications can develop.***

Complicated or not...

Tenuate[®] Dospan[®] ^{IV} **(diethylpropion hydrochloride NF)** **75 mg. controlled-release tablets**

A useful short-term adjunct in an indicated weight loss program.

Overweight patients in certain diagnostic categories often require strict appetite control and a successful program of weight reduction may tend to diminish the incidence or severity of the complications in some patients. Diethylpropion hydrochloride has been reported useful in such patients and while it is not suggested that Tenuate itself in any way reduces the complications of overweight, it may have a useful place as a short-term adjunct in a prescribed dietary regimen. **Tenuate should not be administered to patients with severe hypertension; see additional Warnings and Precautions on the opposite page.**

In uncomplicated overweight.

Many patients, on the other hand, present with excess fat but no disease. While this condition is often termed uncomplicated obesity, complications of both a social and a psychologic nature may be distressingly real for the patients. In these cases, a short-term regimen of Tenuate can help reinforce your dietary counsel during the important early weeks of an indicated weight loss program.

Clinical effectiveness.

The anorectic effectiveness of diethylpropion hydrochloride is well documented. No less than 16 separate double-blind, placebo-controlled studies attest to its usefulness in daily practice.¹ And the unique chemistry of Tenuate provides "...anorectic potency with minimal overt central nervous system or cardiovascular stimulation."² Compared with the amphetamines, diethylpropion has minimal potential for abuse.

**Tenuate—it makes sense.
And it's responsible medicine.**

*Studies have shown that obesity is associated with an increased incidence of hypertension, symptomatic heart disease, adult-onset diabetes, and other diseases.

Merrell



For prescribing information see opposite page.

α

Alpha Stimulation

Central Control of
Blood Pressure*

*The Family of Man by Roberto Moretti,
a statuary in crystal symbolizing the broad range of
hypertensive patients eligible for therapy with Catapres



The Alpha Advantage:

It's for all kinds of hypertensives

- Unlike beta blockers, Catapres® has no contraindications.
- Catapres can be useful even in these patients with:

Congestive heart failure	Allergic rhinitis
Ventricular hypertrophy	Hepatic disease
Hyperglycemia	Hyperuricemia
Diabetes mellitus	Gouty arthritis
Bronchial asthma	Sulfonamide hypersensitivity

Like any antihypertensive, use with caution in severe coronary insufficiency, recent myocardial infarction, cerebrovascular disease or chronic renal failure.

work/play—normal hemodynamic responses to exercise maintained.

love—low incidence of impotence and/or loss of libido:
2.8% in 1,923 patients studied.¹

cardiac output—tends to return to control values during long-term therapy.

blood flow—preserved in kidney.

No Single Advantage Determines Drug Choice.

Other factors must include:

The drug's effectiveness in a given patient, its side effects, warnings, precautions, tolerance, etc. A rational therapeutic choice depends on a careful assessment of all such factors.

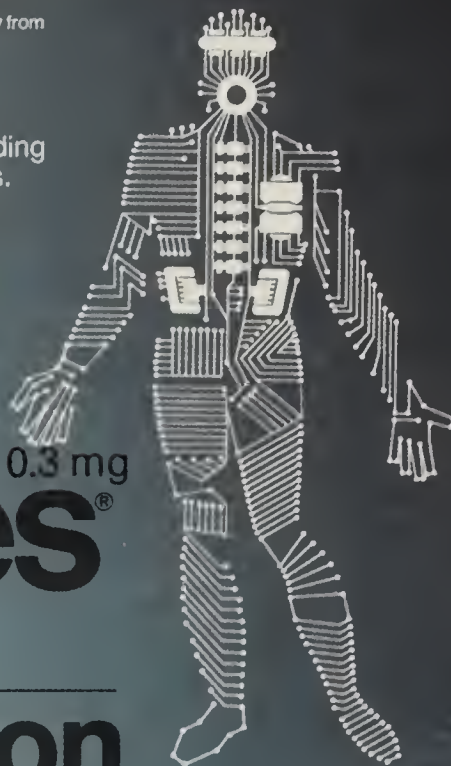
*Central alpha-adrenergic stimulation decreases sympathetic outflow from the brain, as shown in animal studies.

¹ Data on file at Boehringer Ingelheim Ltd.

Please see last page for brief summary, including warnings, precautions, and adverse reactions.

**Now available in new
0.3 mg tablets**

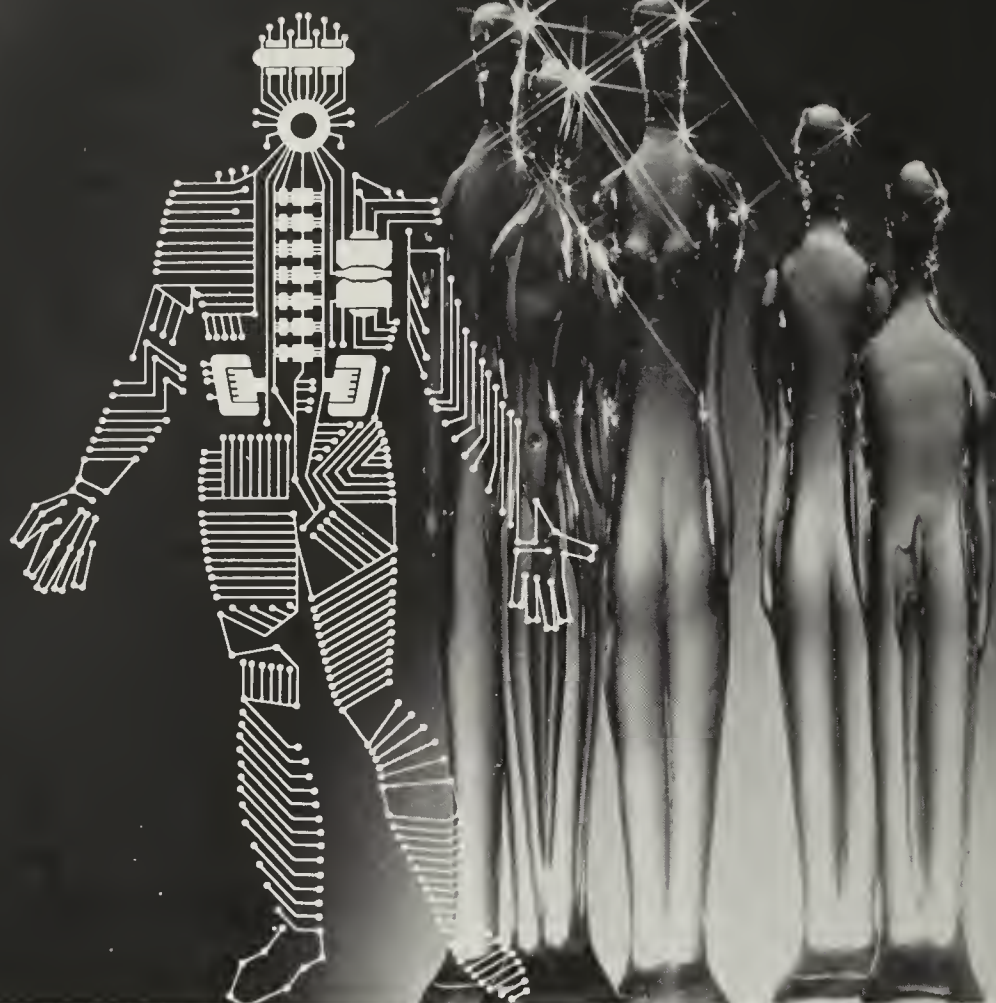
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(clonidine HCl)
Hypertension



- No contraindications.
- Effective in all degrees of hypertension. It is mild to moderate in potency.
- Low incidence of depression, impotence, orthostatic hypotension—no fatal hepatotoxicity.
- Preserves kidney blood flow.

Most common side effects are dry mouth, drowsiness, and sedation which generally tend to diminish with time.

Catapres[®]
(clonidine hydrochloride)
Tablets of 0.1, 0.2, 0.3 mg

Indication: The drug is indicated in the treatment of hypertension. As an anti-hypertensive drug, Catapres (clonidine hydrochloride) is mild to moderate in potency. It may be employed in a general treatment program with a diuretic and/or other antihypertensive agents as needed for proper patient response.

Warnings: Tolerance may develop in some patients necessitating a reevaluation of therapy.

Usage in Pregnancy: In view of embryotoxic findings in animals, and since information on possible adverse effects in pregnant women is limited to uncontrolled clinical data, the drug is not recommended in women who are or may become pregnant unless the potential benefits outweigh the potential risk to mother and fetus.

Usage in Children: No clinical experience is available with the use of Catapres (clonidine hydrochloride) in children.

Precautions: When discontinuing Catapres (clonidine hydrochloride), reduce the dose gradually over 2 to 4 days to avoid a possible rapid rise in blood pressure and associated subjective symptoms such as nervousness, agitation, and headache. Patients should be instructed not to discontinue therapy without consulting their physician. Rare instances of hypertensive encephalopathy and death have been recorded after cessation of clonidine hydrochloride therapy. A causal relationship has not been established in these cases. It has been demonstrated that an excessive rise in blood pressure, should it occur, can be reversed by resumption of clonidine hydrochloride therapy or by intravenous phentolamine. Patients who engage in potentially hazardous activities, such as operating machinery or driving, should be advised of the sedative effect. This drug may enhance the CNS-depressive effects of alcohol, barbiturates and other sedatives. Like any other agent lowering blood pressure, clonidine hydrochloride should be used with caution in patients with severe coronary insufficiency, recent myocardial infarction, cerebrovascular disease or chronic renal failure.

As an integral part of their overall long-term care, patients treated with Catapres (clonidine hydrochloride) should receive periodic eye examinations. While, except for some dryness of the eyes, no drug-related abnormal ophthalmologic findings have been recorded with Catapres (clonidine hydrochloride), in several studies the drug produced a dose-dependent increase in the incidence and severity of

The usual starting dose of Catapres is 0.1 mg at breakfast and 0.1 mg at bedtime. Some patients may benefit from a starting dose of 0.1 mg at bedtime.

Usual daily dose range—0.2—0.8 mg

Maximum daily dose—2.4 mg

Doses as high as this have rarely been employed.

For optimal results, the dose of Catapres must be adjusted according to the patient's individual blood pressure response.

spontaneously occurring retinal degeneration in albino rats treated for 6 months or longer.

Adverse Reactions: The most common reactions are dry mouth, drowsiness and sedation. Constipation, dizziness, headache, and fatigue have been reported. Generally these effects tend to diminish with continued therapy. The following reactions have been associated with the drug, some of them rarely. (In some instances an exact causal relationship has not been established.) These include: Anorexia, malaise, nausea, vomiting, parotid pain, mild transient abnormalities in liver function tests; one report of possible drug-induced hepatitis without icterus and hyperbilirubinemia in a patient receiving clonidine hydrochloride, chlor-thalidone and papaverine hydrochloride. Weight gain, transient elevation of blood glucose, or serum creatine phosphokinase; congestive heart failure, Raynaud's phenomenon; vivid dreams or nightmares, insomnia, other behavioral changes, nervousness, restlessness, anxiety and mental depression. Also rash, angioneurotic edema, hives, urticaria, thinning of the hair, pruritus not associated with a rash, impotence, urinary retention, increased sensitivity to alcohol, dryness, itching or burning of the eyes, dryness of the nasal mucosa, pallor, gynecomastia, weakly positive Coombs' test, asymptomatic electrocardiographic abnormalities manifested as Wenckebach period or ventricular trigeminy.

Overdosage: Profound hypotension, weakness, somnolence, diminished or absent reflexes and vomiting followed the accidental ingestion of Catapres (clonidine hydrochloride) by several children from 19 months to 5 years of age. Gastric lavage and administration of an analeptic and vasopressor led to complete recovery within 24 hours. Tolazoline in intravenous doses of 10 mg at 30-minute intervals usually abolishes all effects of Catapres, (clonidine hydrochloride) overdosage.

How Supplied: Catapres, brand of clonidine hydrochloride, is available as 0.1 mg (tan) and 0.2 mg (orange) oval, single-scored tablets in bottles of 100 and 1000. Also available as 0.3 mg (peach) oval, single-scored tablets in bottles of 100.

For complete details, please see full prescribing information.

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PEER REVIEW EXCHANGE

Central Michigan PSRO ensures appropriate CT scanner use

By Bernard H. Smookler, MD, Lansing

Involvement in medical peer review activities can have many beneficial outcomes. Among these benefits is the comparison of practice patterns which can aid physicians in their effort to improve the quality and cost-effectiveness of medical care.

Our PSRO, Central Michigan Medical Care Review (CMMCR), has taken this prerogative one step further in its effort to assure appropriate access and utilization of CT scanners in the Lansing area.

CT scanners have become an important diagnostic tool in the practice of medicine over the last decade. However, many individuals and groups have questioned how and

where they are being used in our health care communities. CMMCR has initiated a joint project with its primary Health Systems Agency (HSA), the MSU Clinical Center and Edward W. Sparrow Hospital to study CT scanning activity in the region.

CMMCR initiated this joint effort to create a forum on CT scanning activities with those parties who share responsibility for their allocation (the HSA) and operation (Sparrow Hospital and MSU). CMMCR's role, as a PSRO, is to develop the study, analyze the results, and, make appropriate recommendations. It should be stressed that all medical criteria will be developed by a physician's organization — CMMCR.

The study itself has several objectives which were jointly developed by CMMCR and the Michigan

Mid-South Health Systems Agency (MMSHSA). They are as follows:

A. To determine the relative efficacy of CT scanners as diagnostic tools.

B. To assure that CT scanners are used only when medically indicated, and substituted when appropriate for other duplicative, invasive or noninvasive procedures.

C. To assure appropriate access to CT scanners in the region while guarding against unnecessary duplication.

D. To assess the financial impact of CT scanners in terms of economic accessibility and the cost of duplicating procedures which can be substituted, and their effect on other health care costs.

E. To describe the use of CT scanners by medical specialty and to determine if there are identifiable patterns of inappropriate use.

Clearly this project is as ambitious as it is challenging.

Its primary emphasis will be on describing medical practice problems as they relate to use of CT scanners.

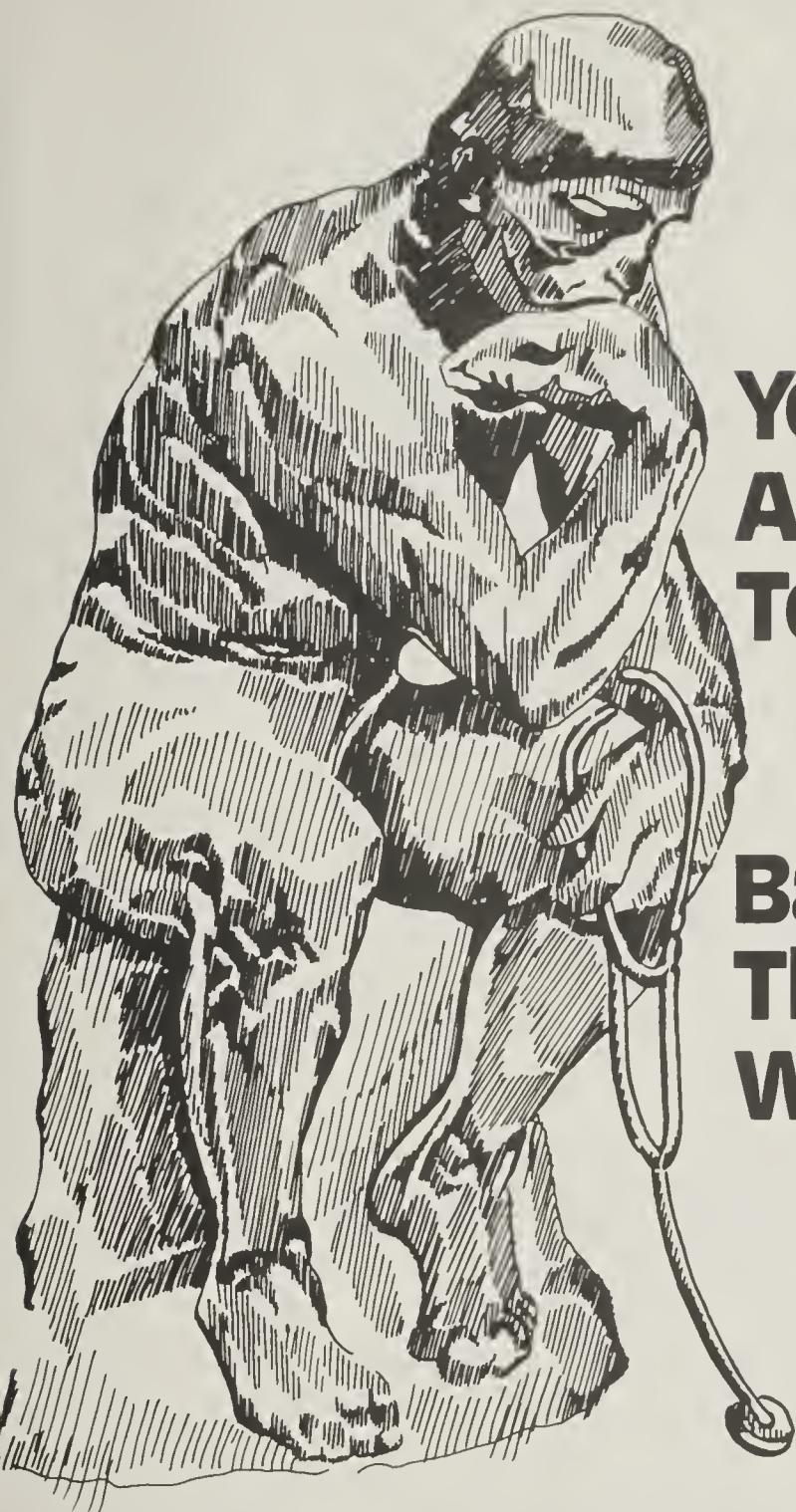
This type of cooperation and involvement has great potential for improving access to medical care services while assuring the appropriate use and quality.

Physician control of the criteria for medical indications of technological procedures is crucial to insure this end.

Doctor Smookler is the President of CMMCR and is a practicing internist in Lansing.

Their years of MSMS service bring recognition to two retiring MSMS councilors at right. Detroit-area Councilors C. Jackson France, MD, left, and Benjamin Jeffries, MD, center, receive plaques at a recent Wayne County Medical Society meeting from MSMS Council Chairman Louis R. Zako, MD.





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There is time yet to register for 1980 MSMS Annual Scientific Meeting



Doctor, have you made your plans yet for attendance at the 1980 MSMS Annual Scientific Meeting?

There still is time to reserve your place in the courses of your choice during the Nov. 18-19-20 event at the Hyatt Regency Dearborn.

There is so much the physician should know about this really extraordinary annual scientific meeting, one of the largest state society-sponsored continuing medical education events in the country.

COURSES: There are 53 half-day courses planned on a wide range of medical topics, to help the practicing physician improve care of patients on a day to day basis.

CREDITS: Each of the 53 courses offers three hours of Category I credit toward the AMA Physician Recognition Award and toward Michigan relicensure. A total of 18 Category I credits may be earned by the physician attending the entire Annual Scientific Meeting. In addition, all but two of the courses also offer American Academy of Family Physicians prescribed credit.

ACLS TRAINING: A special two-day course on advanced cardiac life support is scheduled Wednesday and Thursday, Nov. 19 and 20. The ACLS course is sponsored by the Michigan Chapter, American College of Emergency Physicians, and will award 16 Category I credits. In addition, candidates who successfully complete the testing according to American Hospital Association standards will be certified as pro-

viders in ACLS by the Michigan Heart Association. The course is limited to 48 physicians who have completed the basic cardiac life support course. The fee is \$175.

FACULTY: 53 course directors have organized a faculty of approximately 200 outstanding academic and clinical experts to teach. The faculty members come from a total of 13 states, with Michigan's finest included. In many cases, the course directors and faculty members are the best-received from previous MSMS Annual Scientific Meetings.

FACILITIES: The always-excellent Hyatt Regency Dearborn hotel is the site of this year's Scientific Meeting. MSMS meeting rooms, registration desks and faculty headquarters all are located conveniently this year in the Regency Ballroom area on the first floor of the hotel, to the left of the entry and just past the hotel registration area.

EXHIBITS: The MSMS exhibit hall, adjacent to classroom areas, will feature 75 commercial and educational exhibits designed to assist the physician in procuring services and products of need in daily practice. The exhibit hall also will be the scene of daily luncheons provided by the hotel, and of late afternoon "beer busts" sponsored by MSMS.

Close by the Hyatt Regency are the outstanding historic exhibits of Greenfield Village and the Henry Ford Museum. The hotel itself is connected by an elevated "people mover" to the triple-level Fairlane shopping center. These attractions plus the nearness of the Detroit metropolitan area provide the possibilities of a mini-vacation for the doctor's spouse.

REGISTRATION: Physicians should register for the Annual Scientific Meeting by filling out the registration form and submitting the fees required. The registration form can be found in the Sept. 12 Medigram, the September Michigan Medicine

and the first October Medigram. Copies are available, as well, from MSMS headquarters.

Registrations for the ACLS course were to be made by Oct. 1 and are limited to 48 physicians who have completed the basic CLS course.

Physicians should make room reservations by Nov. 1 to take advantage of the special discount provided by the Hyatt.

FEES: The Annual Scientific Meeting courses cost \$5 per credit hour, or \$15 for each half-day course, for MSMS members. Non-members must pay \$10 per credit hour, or \$30 for each half-day course. The fee for the two-day ACLS course is \$175, which includes an American Heart Association CLS text and other study materials. Residents may attend all but the ACLS course for a fee of \$5 per course.

LUNCHEON: The Hyatt will provide a luncheon each noon in the MSMS exhibition hall. The registration form asks physicians to indicate which days they would like to take advantage of this special arrangement.

SPECIAL EVENTS: Thirteen specialty societies are scheduling business meetings, luncheons, receptions and dinners during the Annual Scientific Meeting. Interested physicians should contact their specialty society offices for tickets and details.

COMMITTEE IN CHARGE: The MSMS Annual Scientific Meeting Task Force is directing the organization of the 1980 MSMS Annual Scientific Meeting. Samuel M. McMahon, MD, Lansing, medical director, Ingham Medical Center, is chairman. Doctor McMahon's committee has worked over a year to plan the event, contacting the state's three medical schools and all its specialty societies to invite them to sponsor a course or two. The advisory committee falls under the aegis of the MSMS CME Programming Committee, led by Carl F. Hammerstrom, MD, Marquette.

Rx: Your CME In One Easy Dose



Your MSMS Annual Scientific Meeting is the easiest prescription for CME you ever had to take. The sweetener that makes this prescription go down easy is the schedule: two courses daily, for three days, at the Hyatt Regency Dearborn. You can choose from over 50 half-day courses and earn up to 18 hours of

Category I Credit. You'll never find a better mixture of medical subjects and fine educators. Why not prescribe a dose of CME for yourself and plan to attend.

**MSMS ANNUAL
SCIENTIFIC MEETING**
November 18-19-20, 1980
Hyatt Regency Dearborn



MEETINGS

MSMS, MSMS/A, AMA and medical assistants

Oct. 15 — AMA meeting, "Newer Clinical Approaches to Sexually Transmissible Diseases," contact: Department of Environmental, Public and Occupational Health, AMA, 535 N. Dearborn St., Chicago, 60610.

Oct. 17-28 — MSMS/Intrav Western Mediterranean Air/Sea Cruise, contact: Marcelyn Ireland, MSMS headquarters. 517/337-1351.

Oct. 22 — MSMS Council, MSMS headquarters, contact: Warren Tryloff, MSMS headquarters.

Oct. 24-25 — AMA Fourth National Conference on Medical Care and Health Services in Correctional Institutions, Chicago, contact: AMA Correctional Programs, 535 N. Dearborn St., Chicago, 60610.

Oct. 28-29 — MSMS/A "Grand Rounds" Fall Education Conference, Kellogg Center, MSU, East Lansing, contact: Caroline Rich, MSMS headquarters.

Oct. 29-Nov. 1 — AMA Fourth National Conference on the Impaired Physician, Baltimore, MD, contact: Department of Mental Health, AMA, 535 N. Dearborn St., Chicago, 60610.

Oct. 30 — First Annual MSMS Public Affairs Leadership Conference, Long's Convention Center, Lansing,

contact: William Madigan or Kevin Kelly, MSMS headquarters. 517/337-1351.

Nov. 8-9 — Fall Leadership Training Seminar, State of Michigan Branch, American Association of Medical Assistants, contact: Caroline Rich, MSMS headquarters.

Nov. 9 — Board Meeting, State of Michigan Branch, American Association of Medical Assistants, contact: Caroline Rich, MSMS headquarters.

Nov. 18-20 — MSMS Annual Scientific Meeting, Hyatt Regency Dearborn, contact: Sherry Fent, MSMS headquarters.

Dec. 3 — MSMS Council, MSMS headquarters, contact: Warren Tryloff, MSMS headquarters.

Dec. 7-10 — AMA House of Delegates, San Francisco, contact: AMA, 535 N. Dearborn St., Chicago, 60610.

Jan. 4-7, 1981 — 7th AMA State Health Legislation Meeting, Sonesta Beach Hotel and Tennis Club, Key Biscayne, FL, contact: Department of State Legislation, AMA, 535 N. Dearborn St., Chicago, 60610.

Feb. 20-Mar. 7, 1981 — MSMS/Intrav South African Adventure, contact: Marcelyn Ireland, MSMS headquarters. 517/337-1351.

Other meetings

Oct. 19-23 — 108th Annual Meeting of the American Public Health Association, Detroit, contact: American

Public Health Association, 1015 15th St., N.W., Washington, D.C. 20005.

Oct. 20-22 — Michigan Rehabilitation Association Conference, "A New Focus: Implications for Service," Marriott Inn, Grand Rapids, contact: Florence Johnson, 1020 Hastings St., Traverse City, 49684. 616/947-6460.

Oct. 25-30 — Annual Meeting, American Academy of Pediatrics, Detroit, contact: Robert S. Holm, MD, Southwestern Michigan Area Health Education Center, 252 E. Lovell St., Kalamazoo, 49007. 616/383-6360.

Nov. 5 — Membership Meeting, Michigan Dermatological Society, University of Michigan, Ann Arbor, contact: Alejandro Morales, MD, 1015 Fernwood, Royal Oak, 48067.

Nov. 5 — Board Meeting, Michigan Chapter, American College of Emergency Physicians, MSMS headquarters, contact: Michigan Chapter, ACEP, P.O. Box 1611, East Lansing, 48823. 517/332-6500.

Nov. 6 — Michigan Family Practice Research Day IV, sponsored by Department of Family Practice, Michigan State University and Michigan Academy of Family Physicians, at MSU University Club, contact: Doug McKeag, MD, Department of Family Practice, B-100 Clinical Center, Michigan State University, East Lansing, 48824. 517/353-0770.

Nov. 12 — Michigan League for Human Services 68th Annual Conference, Cobo Hall, Detroit, Contact: Kathy Yorkievtz, Conference Coordinator, 517/487-5436.

Nov. 19 — Business Meeting, Michigan Dermatological Society, Hyatt Regency Dearborn, contact: Alejandro Morales, MD, 1015 Fernwood, Royal Oak, 48067.

Nov. 19 — Annual Membership Meeting, Michigan Society of General Surgeons, Hyatt Regency Dearborn, contact: Caroline Rich, MSMS headquarters. 517/337-1351.

Nov. 19 — Business Meeting, Michigan Society of Colon and Rectal Surgeons, Hyatt Regency Dearborn, contact: Robert E. McKnight, MD, 15901 West 9 Mile Road, Southfield 48075.

Nov. 20 — Membership Meeting, Michigan Chapter, American College of Chest Physicians, Hyatt Regency Dearborn, contact: Marcelyn Ireland, MSMS headquarters. 517/337-1351.

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CATEGORY I COURSES

Michigan Medicine each month carries a list of opportunities in Michigan for doctors of medicine to obtain Category I credit toward meeting the requirements of Michigan law. Sponsors of Category I programs and courses in Michigan are invited to submit information for the monthly calendar.

Each listing below, of programs that carry at least 3 hours of Category I credit, indicates a contact person, so the physician can obtain details. Physicians with questions about accredited programs may phone MSMS Headquarters, 517/337-1351.

Date: Oct. 18, **You Could Go to Court: Professional Liability — Medical and Legal Issues.** **Location:** Michigan Inn, Southfield. **Sponsor:** U-M Continuing Medical Education Department. **For:** All interested physicians. **Cost:** \$100. **Contact:** Towsley Center, 313/764-2287. **Approved for:** 7½ hours of Category I Credit.

Date: Oct. 20-22, **Blood Coagulation: Clinical and Laboratory Aspects.** **Location:** Towsley Center, Ann Arbor. **Sponsor:** U-M Office of Continuing Medical Education. **For:** All interested physicians. **Cost:** \$200.00. **Contact:** Towsley Center for CME, 313/764-2287. **Approved for:** 20½ hours of Category I Credit.

Date: Oct. 24-25, **Nutritional Support of the Hospitalized Patient.** **Location:** Towsley Center, Ann Arbor. **Sponsor:** U-M Office of Continuing Medical Education. **For:** All interested physicians. **Cost:** \$110. **Contact:** Towsley Center for CME, 313/764-2287. **Approved for:** 9½ hours of Category I Credit.

Date: Oct. 25, **Pulmonary Emergencies.** **Location:** Education and Research Center, Henry Ford Hospital. **Sponsor:** Henry Ford Hospital.

For: All interested physicians. **Contact:** Medical Education, Henry Ford Hospital, 2799 W. Grand Blvd., Detroit 48202 313/876-1464. **Approved for:** 7 hours of Category I Credit.

Date: Nov. 7-8, **Leukemias and Non-Hodgkin's Lymphomas: Clinico-Pathological Update.** **Location:** Hilton Inn, Lansing. **Sponsor:** Department of Laboratories, Edward W. Sparrow Hospital. **For:** All interested physicians. **Contact:** Janice Proudfoot, Education Coordinator, Edward W. Sparrow Hospital, 1215 E. Michigan Ave., P.O. Box 30480, Lansing, 48909. 517/487-2530. **Approved for:** 5 hours of Category I Credit.

Date: Nov. 8, **Symposium on Empathy and Countertransference.** **Location:** Hyatt Regency Dearborn. **Sponsor:** Michigan Psychoanalytic Society. **For:** Psychiatrists. **Contact:** The Michigan Psychoanalytical Society, 16310 West Twelve Mile Rd., Suite 204, Southfield, 48076. **Approved for:** 6 hours of Category I Credit.

Date: Nov. 12, **20th Annual Thyroid Workshop.** **Location:** Scott Hall, Detroit Medical Center. **Sponsor:** Wayne State University Office of CME.

For: All interested physicians. **Contact:** Ms. Anita Tompkins, 313/577-1180. **Approved for:** 6 hours of Category I Credit.

Date: Nov. 13-14, **Seminar on Quality Assurance.** **Location:** Detroit. **Sponsor:** Joint Commission on Accreditation of Hospitals. **Co-Sponsor:** Michigan Hospital Association. **For:** Hospital management, medical and nursing staffs. **Contact:** Maryanne Butt, Michigan Hospital Association, 2213 E. Grand River, Lansing, 48912, 517/484-7441. **Approved for:** 11 hours of Category I Credit.

Date: Nov. 14-15, **Twenty-Eighth Annual Symposium on Trauma.** **Location:** Harper Hospital, Kresge Auditorium, Detroit. **Sponsor:** Michigan Committee on Trauma of the American College of Surgeons and the Department of Surgery of Wayne State University. **For:** All interested physicians. **Cost:** Physicians — \$60.00, Residents — \$30.00. **Contact:** Charles E. Lucas, MD, Chairman, 313/494-3485. **Approved for:** 9 hours of Category I Credit.

Date: Nov. 17-18, **Treatment of Injuries of the Hand: Primary and Definitive Care.** **Location:** Detroit Plaza Hotel. **Sponsor:** Wayne State University School of Medicine, Department of Surgery and American Society for Surgery of the Hand. **For:** All interested physicians. **Cost:** \$250. **Contact:** Gerald F. Prieur, Jr., MPA, Wayne State University School of Medicine, Continuing Medical Education, 9B-32 Health Care Institute, Detroit, 48202, 313/577-1180. **Approved for:** 19 hours of Category I Credit.

Date: Nov. 18-20, **MSMS Annual Scientific Meeting.** **Location:** Hyatt Regency Dearborn. **Sponsor:** Michigan State Medical Society. **For:** All interested physicians. **Contact:** Sherry Fent,

continued on page 546

OB-GYN, RADIOLOGY, GENERAL SURGERY, ORTHOPEDIC SURGERY UROLOGY, GASTROENTEROLOGY.

The U.S. Army Health Services Command has vacancies for civilian medical officers in lovely, tropical Panama. Work at Gorgas Army Hospital — modern 300-bed acute care hospital with 160 beds occupied, and 550 daily outpatient visits.

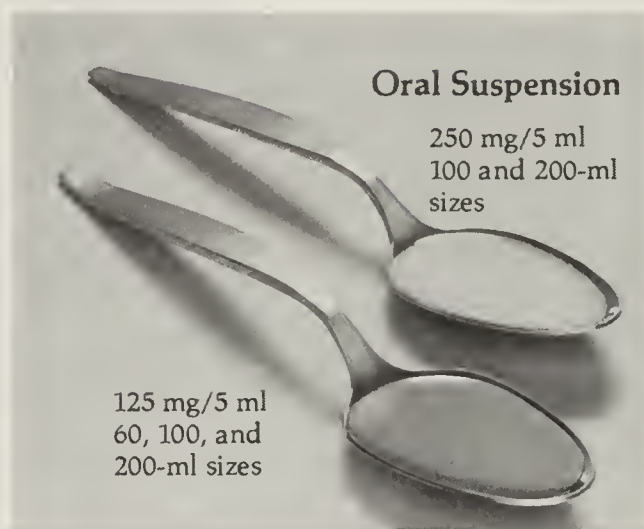
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MSMS Annual Scientific Meeting to feature educational exhibits

MSMS members attending the 1980 MSMS Annual Scientific Meeting will be welcomed by MSMS staff members manning a new, deluxe exhibit of MSMS programs.

Members are invited to stop by the exhibit for information on MSMS educational, legislative, communication and member benefit programs. The exhibit will be manned from 8

a.m. to 5 p.m. all three days of the Annual Scientific Meeting, and will include brochures, benefit program applications, official publications and membership forms.

Physicians attending the MSMS Annual Scientific Meeting may visit six educational booths offered by private citizens and public agencies who will present their special messages. They include:

Larry H. Bates, MD, Indianapolis, and his popular anti-smoking campaign materials featuring "Bates Buttons and T-shirts;"

Thad H. Joos, MD, with a poster presentation on an open camp for asthmatics. The exhibit will be entitled "The Michigan Experience," and will be cosponsored by the Michigan Allergy Society;

The Michigan Department of Education's Disability Determination Service which will be on hand to describe the system by which physicians certify a person's disabilities;

Physicians assistant programs at Mercy College of Detroit and Western Michigan University;

The National Foundation of Ileitis and Colitis, Inc., which will display an educational exhibit on services, and research provided by the self-help group, and

The United Ostomy Association, a self-help group for people with colostomy, ileostomy and urinary diversion, which also will exhibit.

CATEGORY I/Continued

MSMS, 517/337-1351. **Approved for:** 18 hours of Category I Credit.

Date: Nov. 28- Dec. 2, **Ophthalmology: Basic and Clinical Review.** **Location:** Hyatt Regency Dearborn. **Sponsor:** Wayne State University School of Medicine and Kresge Eye Institute. **For:** All interested physicians. **Contact:** Gerald F. Prieur, Jr., MPA, Program Coordinator, 313/577-1180. **Approved for:** 42 hours of Category I Credit.

Date: Dec. 3, **Perspectives In Surgery.** **Location:** Saint John Hospital, Detroit. **Sponsor:** Saint John Hospital. **For:** All interested physicians. **Cost:** \$100. **Contact:** Ms. Linda Radu, Office of CME, Saint John Hospital, 22101 Moross Rd., Detroit, 48236. 313/343-4000. **Approved for:** 8 hours of Category I Credit.

Date: Dec. 5-6, **Immunology and Allergy Review.** **Location:** Scott Hall, Detroit Medical Center. **Sponsor:** Wayne State University Office of CME. **For:** All interested physicians. **Contact:** Ms. Anita Tompkins, 313/577-1180. **Approved for:** 9½ hours of Category I Credit.

Date: Dec. 6, 1980, **Practical Management of Common Neurosurgical Problems.** **Location:** Borgess Medical Center, Kalamazoo. **Sponsor:** Neurosurgery of Kalamazoo, P.C. and Borgess Medical Center. **Co-Sponsor:** Southwestern Michigan Area Health Education Center. **For:** All interested physicians. **Cost:** \$25. **Contact:** Charles L. Zeller, Jr., MD, SMAHEC, 252 E. Lovell, Kalamazoo, 49007. **Approved for:** 6 hours of Category I Credit.

Date: Dec. 13, **General Pathologic Problems Encountered in the Practice of Forensic Pathology.** **Location:** Towsley Center, Ann Arbor. **Sponsor:** Michigan Society of Pathologists. **For:** Pathologists. **Contact:** T. A. Reyman, MD, Department of Pathology, Mt. Carmel Mercy Hos-

pital, Detroit, 48235. **Approved for:** 3 hours of Category I Credit.

Date: Jan. 21, 1981, **Current Advances in Hepatitis and Liver Diseases.** **Location:** St. John Hospital, Detroit. **Sponsor:** St. John Hospital. **For:** All interested physicians. **Cost:** \$100. **Contact:** Ms. Linda Radu, Continuing Medical Education, 313/343-3877. **Approved for:** 8 hours of Category I Credit.

Date: Feb. 14, 1981, **A Practical Endocrinologic Approach for the Diagnosis of Thyroid and Adrenal Disorders.** **Location:** Henry Ford Hospital, Detroit. **Sponsor:** Michigan Society of Pathologists. **For:** All interested physicians. **Contact:** T. A. Reyman, MD, Department of Pathology, Mt. Carmel Mercy Hospital, Detroit, MI 48236. **Approved for:** 3 hours of Category I Credit.

Date: Feb. 20-22, 1981, **Practical Otolaryngology.** **Location:** Dearborn Inn, Dearborn. **Sponsor:** Wayne State University Office of CME. **For:** All interested physicians. **Contact:** Ms. Anita Tompkins, 313/577-1180. **Approved for:** 12 hours of Category I Credit.

Date: March 4, 1981, **Adolescent Gynecology and Obstetrics.** **Location:** St. John Hospital, Detroit. **Sponsor:** St. John Hospital. **For:** All interested physicians. **Cost:** \$100. **Contact:** Ms. Linda Radu, Continuing Medical Education, 313/343-3877. **Approved for:** 8 hours of Category I Credit.

Date: April 1-4, 1981, **Aesthetic and Reconstructive Surgery of the Head and Neck.** **Location:** Campus Inn, Ann Arbor. **Sponsor:** Department of Otolaryngology, University of Michigan Medical Center. **For:** All interested physicians. **Cost:** \$500. **Contact:** Shan R. Baker, MD, Dept. of Otolaryngology, University of Michigan Medical Center, Ann Arbor, 48109. **Approved for:** 28 hours of Category I Credit.

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Wednesday,
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Grand Rounds' session Oct. 28-29 to kick off Auxiliary speakers bureau

by Donna Chase, MSMS/A President

A "Grand Rounds" Education Conference will highlight the 1980 fall program for the MSMS Auxiliary.

"Grand Rounds," Oct. 28-29, was designed to provide all auxiliaries with public relations, leadership and speaking skills which will help make the physician's spouse a more knowledgeable person on medical issues of today, as well as a more confident leader in the community and in auxiliary work.

The leaders of "Grand Rounds" will be outstanding: Edward Annis, MD, former AMA President; Paul Machette, president of Omnicom Productions, Inc., Lansing, communications specialists; John Ylvisaker, MD, MSMS president, Mrs. Richard Rapport and Mrs. Earl Weston, auxiliaries active in the field of management by objective training and parliamentary procedure.

This meeting, at Kellogg Center in East Lansing, also is designed to provide the leadership (or know-how) necessary for local auxiliaries to return to their communities and establish local speakers bureaus.

Contact with local organizations should bring about better communications between the physician's family and the public.

News media pressure is not presently on the medical profession, because of the election year and the economy. This provides the auxiliary an ideal time to help educate friends or the public to the views of the physician, MSMS and the AMA.

This new program is to replace the two fall district meetings. A joint meeting will provide outstanding speakers, take advantage of services and the leadership of MSMS as well as an opportunity to meet with and share ideas with auxiliaries across the state.

"Grand Rounds" has been developed by the newly formed Education Committee of MSMS/A and the district directors. Through the efforts of these two groups, stronger leadership has been developed to aid the local auxiliary. An informed auxiliary can better promote the goals of MSMS and the county medical society.

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NEWS

**By Bonnie L. Groff,
MSMS staff**



Doctor Helmrath



Doctor Hess



Doctor Kahkonen



Doctor Krabbenhoft

Thomas A. Helmrath, MD, East Lansing, is new vice chancellor for health affairs of the Ohio Board of Regents. In his new position, Doctor

Helmraht will have leadership responsibility for planning and coordinating Ohio's state system of health education programs. . . .New president of the American Diabetes Association-Michigan Affiliate is **Dorothy Kahkonen, MD**, Dearborn. . . .**Donald L. Rucknagel, MD**, Ann Arbor, a University of Michigan genetic scientist, is one of two U-M recipients of a \$35,000 grant from the March of Dimes to fund clinical research projects. Doctor Rucknagel has started a research program to develop a safe, inexpensive blood test for parents to detect hereditary anemias, such as sickle cell anemia, in their unborn children. . . .**Kenneth L. Krabbenhoft, MD**, Detroit, is new secretary of the American Board of Radiology. Doctor Krabbenhoft was elected for a six year term. . . .**Sidney Kobernick, MD**, and Associates, pathologists of Sinai Hospital, have created the Saul Brown Memorial Prize in Pathology to annually recognize one sophomore medical student's outstanding performance in the study of pathology. The first award will be given in May, 1981. . . .President of the newly formed American Association of Endocrine Surgeons is **Norman W. Thompson, MD**, Ann Arbor. . . .**Harvey V. Sparks, Jr., MD**, East Lansing, has been appointed by the National Board of Medical Examiners to serve on its physiology test committee. The board's corps of examiners, which includes more than 100 individuals selected from the foremost teachers of medicine in the United States and Canada, is a fundamental component of the board's examination system for the nation's MDs. . . .**Joseph N. Schaeffer, MD**, president emeritus of the Rehabilitation Institute in Detroit, and **Richard L. Sejnost**, executive vice president of Harper-Grace Hospitals in Detroit, are recipients of the Michigan Hospital Association's highest honor — its key for meritorious service. The awards, for outstanding contributions of service to hospitals and to the health care needs of the people of Michigan, were presented at the MHA's Annual House of Delegates meeting. . . .**Joseph W. Hess, MD**, Detroit, is the first recipient of the Wayne State University Medical Alumni Association's Endowed Chair in Family Medicine. . . .**Dorin L. Hinerman, MD**,

Ann Arbor, was recently re-elected a vice-chairman on the Michigan Cancer Foundation Board of Trustees. . . .**Liborio Tranchida, MD**, Southfield, of Harper-Grace Hospitals, is the first recipient of the Paul E. Ruble Memorial Award. The award is given annually to the physician who contributes the most to the education of house staff and students in the Department of Medicine at Harper Hospital. . . .**Horace W. Davenport, PhD**, Ann Arbor, recently received the American Gastroenterological Association's Friedenwald Medal, the association's highest award. Doctor Davenport earned the award for "outstanding achievement in gastroenterology," based on his writing and research. . . .New director of McLaren Hospital's coronary care unit and cardiac rehabilitation program is **Daniel Anbe, MD**, Flint. . . .**Thomas O. Miyata, MD**, St. Joseph, has been elected president of the Berrien County Heart Unit, an affiliate of the Michigan Heart Association. . . .The latest issue of the University of Michigan Medical Center Journal is entitled the **James L. Wilson** Issue. Doctor Wilson served as professor and chairman of pediatrics and communicable diseases at the U-M from 1944 to 1967 and as president of the American Pediatric Society from 1963 to 1964. . . .**Jack Ryan, MD**, Detroit, was elected to the Michigan Hospital Association Board of Trustees, and will serve a one-year term. . . .An interview with **Frank M. Ochberg, MD**, director of the Michigan Department of Mental Health, appears in the special issue of *Evaluation and Change*. The interview entitled, "Evaluation as a Tool for Restoring the Mental Health of Victims," relates Doctor Ochberg's ideas on what programs work best in aiding victims of violence. . . .**Joseph A. Sentkeresty, MD**, Grand Rapids, is a new trustee of the American Society of Internal Medicine. . . . "Cost Containment Through Medical Education," an article by **Israel Praiss, MD**, Ann Arbor, appears in the July 4 issue of JAMA. . . .The July 25 JAMA contains the article, "Losing Weight Through Exercise," by **Barry A. Franklin, PhD**, and **Melvyn Rubenfire, MD**, both of Detroit.

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avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE**

REACTIONS: Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. **In the male:** Eunuchoidism and eunichism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpuberal cryptorchism, 30 mg. **REFERENCE:** R. B. Greenblatt, M.D.; R. Witherington, M.D.; I. B. Sipahioglu, M.D.: Hormones for Improved Sexuality in the Male and the Female Climacteric. *Drug Therapy*, Sept. 1976. **SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only.

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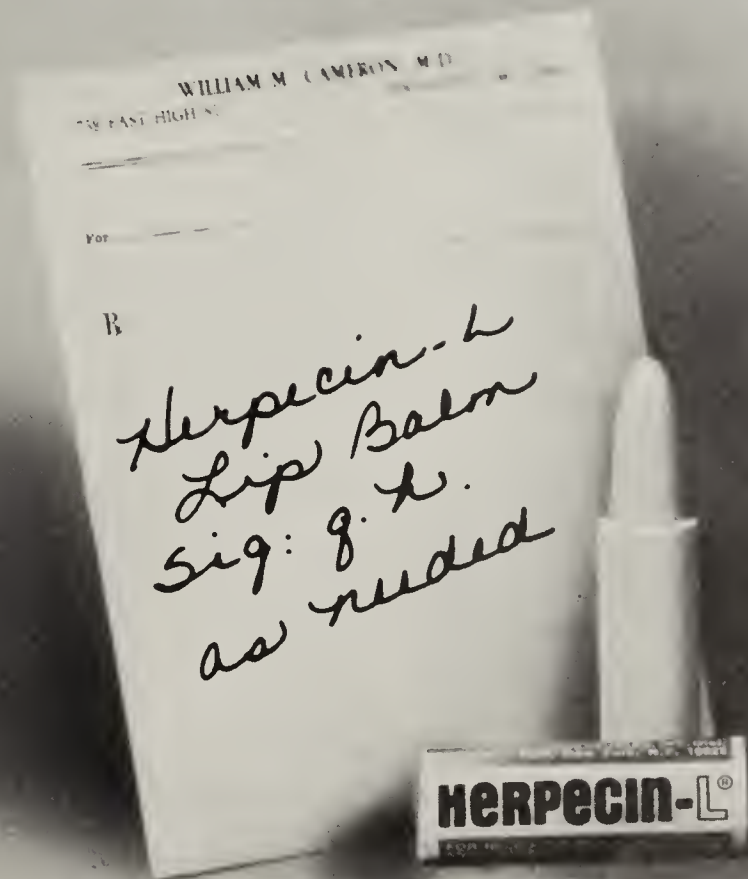
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The First Annual MSMS Public Affairs Leadership Conference is being held on Oct. 30 at Long's Convention Center, Lansing.

The 1980 MSMS House of Delegates enthusiastically challenged MSMS and the medical community to make an aggressive effort to prepare and inform physician leaders. Thus, this program will concentrate

on those professional, socioeconomic, political and administrative trends, ideas and problems that are clearly and, in some cases, ominously, visible on the professional horizon for every practicing physician today.

This promises to be a day well spent in professional growth and fellowship!

The program

9:00 REGISTRATION

9:30 CALL TO ORDER — John R. Ylvisaker, MD, MSMS President

9:45 "AMERICA AT THE POLLS" — Richard Scammon, Director, Elections Research Center, Washington, DC

10:45 "POLITICAL ACTION — MDPAC" — Thomas C. Payne, MD, Chairman, Michigan Doctors Political Action Committee

11:00 "FEDERAL TRADE COMMISSION DEVELOPMENTS" — Louis R. Zako, MD, Chairman, Michigan State Medical Society Council

11:15 "ON THE STAND . . ." — A. Stewart Kerr, MSMS Legal Counsel, Kerr, Russell and Weber, Detroit

11:30 "REVIEW, PREVIEW AND PROGNOSTICATIONS FROM THE UNITED STATES SENATE" — Honorable Carl Levin, United States Senator

12:15 LUNCH — Luncheon Speaker, Robert T. Kelly, MD, Minnesota, AMA Board of Trustees

1:30 "INTERNAL OPERATIONS AT MSMS HEADQUARTERS" — Thomas Berglund, MD, Vice-Chairman, MSMS Council

2:00 "MEDICAID DURING THE MICHIGAN RECESSION" — David Siegel, MD, Chairman, Medicaid Liaison Committee

2:20 "BLUE CROSS/BLUE SHIELD REFORM" — W. E. Maldonado, MD, Chairman, Committee on State Legislation and Regulations

2:40 "GROWTH IN HMO-IPA PREPAYMENT PLANS IN MICHIGAN" — Jay Harness, MD, Chairman, Advisors to the Bureau of Economics

3:00 "PSRO-OUR UNITED EFFORT" — Daniel J. Fall, MD, President, Michigan Statewide Professional Standards Review Council Inc.

3:15 "PROFESSIONAL LIABILITY INSURANCE IN MICHIGAN" — Robert M. Leitch, MD, President, Michigan Physicians Mutual Liability Company

3:30 "THE NATURE OF LEADERSHIP IN MEDICINE: There's a Lot We Physicians Can Do" — Ed Annis, MD, Former AMA President, Presently — Consultant, Mutual Association for Professional Services

Please return to:

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DOCTOR YLVISAKER/Continued

ings to the subscriber directly for lowered premium costs.

2. There must be incentives for providers — negative in the form of having to answer for large or high cost of service, and positive in the form of participation in achieved savings.

3. Tax treatment of health care costs and insurance benefits must be uniform for all, whether premiums are paid by the employer or by the individual. Tax credits may need to be considered for additional incentive.

4. Free enterprise principles are essential to encourage open competition, to assure provider and patient rights and to foster cost-efficiency as well as profit potential for providers.

5. Providers must be made accountable and be placed at financial risk for unit and aggregate costs of service.

6. Providers must be required and allowed to be accountable for the quality of services rendered.

The question is: Can we "reverse our field" and get back to common sense reimbursement but still accommodate the complexity of needs in our modern world?

There are some brave souls who think we can. We'll next examine some possibilities.



Full service benefit reimbursement — What Do You Really Think?

By John R. Ylvisaker, MD, MSMS President

The discussion in last month's President's Page dealt with the inherent and fundamental faults of the full-service benefit reimbursement system. It identified how the system negatively affects consumers' and providers' behavior.

Most seriously for physicians and hospitals, it warned that this system has placed the control of the health care industry in the hands of those who now control the flow of dollars, i.e. government and third party payors.

How does the record reflect what doctors think about this system? What, if anything, do doctors want in the way of change? And what does the medical profession require in any system of reimbursement to ensure sound and ethical medical practice?

My sources of information for answers are not much different than the rest of you who give thought to these matters:

1. Actions of the House of Delegates of the last 12 to 15 years.
2. MSMS Council and staff actions.
3. "Coffee table" and informal discussions.

What physicians stand for

According to the record, here is what MSMS physicians then stand for that must be considered in any reimbursement system:

1. A free enterprise environment of medical practice, including:
 - a. Free choice of physicians by patients;
 - b. Free choice of patients by physicians;

- c. The right to set fees and bill for services rendered (thus opposing arbitrary control and profiling of fees);

- d. The right to a pluralistic system for delivery of health care (i.e. fee-for-service practice, prepayment or capitation funding, HMO or conventional reimbursement insurance);

- e. The right to participate or not to participate in plans for reimbursement without involuntary economic or third party coercion;

- f. The right to make, and be accountable for, clinical decisions (i.e. opposing third party interference with clinical judgments) and;

- g. The right to make, and live with the consequences of, economic decisions (i.e. opposing regulatory controls).

2. High standards of physician ethics and honesty as well as of physician/patient accountability, including:

- a. Quality assurance by physician direction of peer review

- b. Confidentiality of patient and peer review records

- c. Avoidance of patient or physician exploitation, unreasonable fees, or unjustifiable (unnecessary) care

- d. Full and adequate disclosure of fees and benefits

3. The employment of sound and equitable financial principles for payment of health care services, through:

- a. Direct patient responsibility for at least partial payment of charges or of insurance premiums thru deductibles, co-pay-

ments, or other first-dollar coverage mechanisms

- b. Equal tax treatment of insurance premium costs

- c. Equal reimbursement for equal services

- d. Prompt claim payment for reasonable fees

In spite of these articulated positions, physicians live with the economic realities of the status quo. While the "coffee table" discussion is replete with stories of payments according to unfair fee "profiles," unequal payments for equal services in the same community, overutilization caused by lack of cost-consciousness, or overt exploitation of the payment system to increase income, only the rare physician dares to buck the system by direct billing of insured patients.

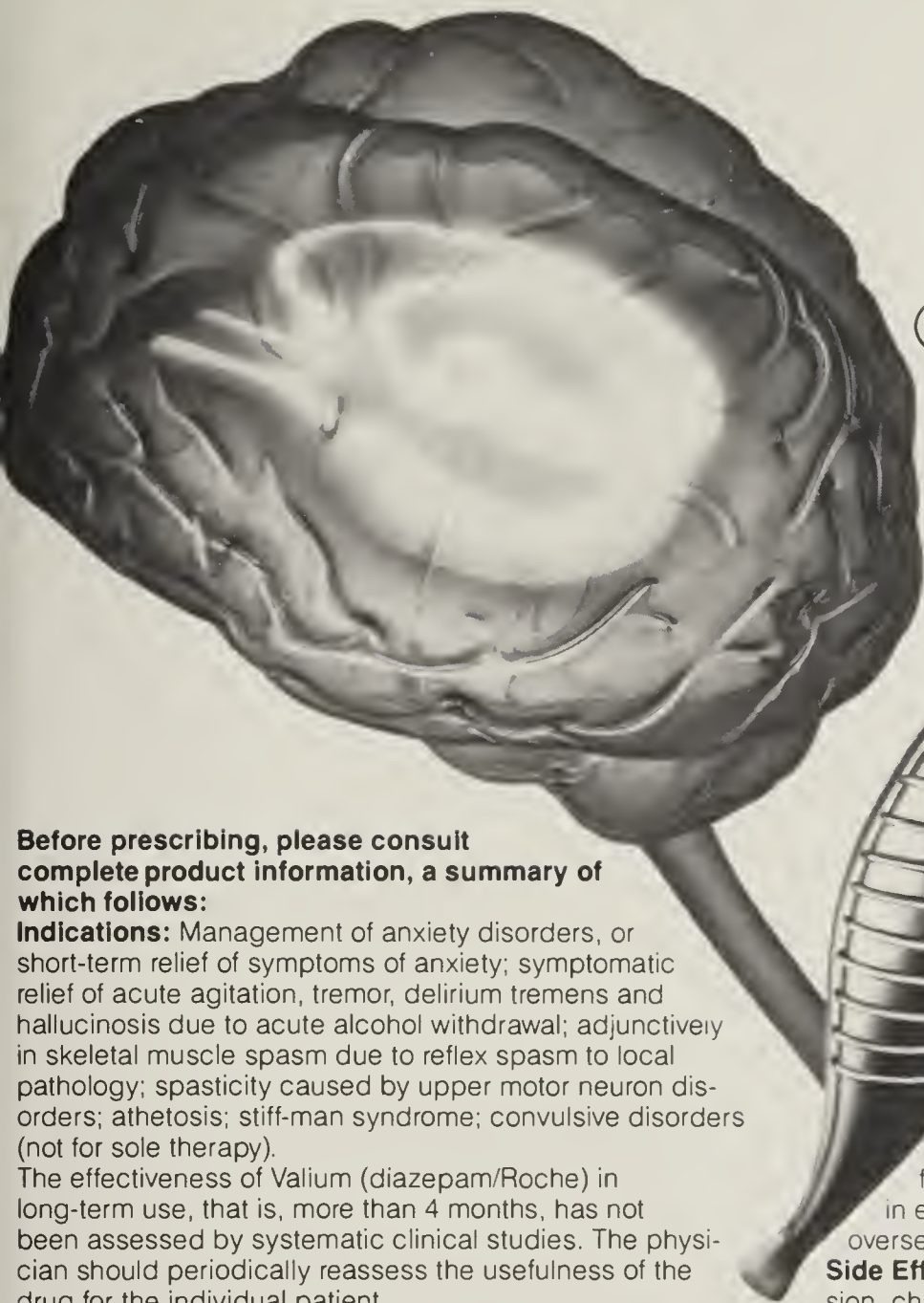
Interestingly, the above doesn't touch on the hospital side of the reimbursement equation where the nearly 100 percent full service benefit system is comfortably based on "cost-plus" charges whether "prospective" or for services already rendered.

What physicians want

What, then, are characteristics of alternative systems most generally conceded to be requisite in any modification or replacement of the present full-service benefit approach?

1. There must be incentives and/or rewards for subscriber cost-consciousness — first-dollar responsibility for payment for services or partial-dollar responsibility for premium costs, or sav-

(continued on page 555)



Only Valium® (diazepam/Roche)
is indicated in anxiety
disorders and as
an adjunct
in the relief
of skeletal
muscle spasm

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Management of anxiety disorders, or short-term relief of symptoms of anxiety; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology; spasticity caused by upper motor neuron disorders; athetosis; stiff-man syndrome; convulsive disorders (not for sole therapy).

The effectiveness of Valium (diazepam/Roche) in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms similar to those with barbiturates and alcohol have been observed with abrupt discontinuation, usually limited to extended use and excessive doses. Infrequently, milder withdrawal symptoms have been reported following abrupt discontinuation of benzodiazepines after continuous use, generally at higher therapeutic levels, for at least several months. After extended therapy, gradually taper dosage. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

Dosage: Individualize for maximum beneficial effect.

Adults: Anxiety disorders, symptoms of anxiety, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. **Geriatric or debilitated patients:** 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) **Children:** 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

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MEDIGRAM

CAPSULES

FOUR HUNDRED MSMS MEMBERS will be informed by letter soon that they have been randomly selected to take part in an MSMS survey on a master member pension program. "We are considering this new benefit for members: a pension program tailored to fit the specialized needs of physicians and their employees," says Justin L. Sleight, MD, Lansing, chairman of the MSMS Master Pension Program Task Force. The letters will be followed by telephone calls from Kennedy Research, Inc., of Grand Rapids, which has been retained by MSMS to make the survey. Members will be asked by telephone how they feel about such an offering and which specific plans would best suit various types of practices. "Members' cooperation and suggestions will be greatly appreciated," says Doctor Sleight.

THE MICHIGAN DEPARTMENT of Public Health has one year to develop rules and regulations for Michigan hospices, now that their licensure is required by law. HB 4909, which calls for hospice licensure/regulation by the MDPH, was signed into law recently by the governor. It places the hospice programs for the terminally ill under the public health code and the certificate of need act.

MSMS SALUTES the American Academy of Pediatrics, holding its 50th anniversary meeting Oct. 25-30 in Detroit, its founding city!

Council asks legislative equity for Medicaid reductions

The MSMS Council is calling for high legislative priority on reinstating annual Medicaid reimbursement screen updates equitable with current Medicare levels. The Council is responding to the Department of Social Services' recently-announced plans to reduce Medicaid reimbursements to providers by 15 percent, effective Dec. 15, due to the state's strained economy. Reinstating annual Medicaid screen updates to current Medicare levels is an equitable departure point from which the state may make necessary reductions, the committee reported to The Council. There have been no Medicaid reimbursement screen updates since 1977, however, while at the same time Medicare screens have risen a compounded 31 percent.

Medicaid Liaison Committee members by conference call Oct. 21 decided to recommend that MSMS direct efforts toward state acknowledgement of, and legislative relief from, the actual burden being asked of physicians, which is a total 46 percent short-fall in Medicaid payments.

Review professional liability rates and information with caution

MSMS has learned that medical society members are receiving incorrect information in the mail on the professional liability insurance company which succeeded the Brown-McNeely Fund. The Physicians Insurance Company of Michigan which succeeded the Fund late this summer mailed sales brochures, invoices and binders to MSMS members which stated incorrect rates for certain classes and coverages. A telephone confirmation with the company revealed a mistake was made, and the sales materials had been printed based on incorrect rates. "We had to recall them," said the spokesman in the company's underwriting division. "The insurance bureau told us to correct the rates."

To clarify details, MSMS encourages physicians to contact the Michigan Physicians Mutual Liability Company (MPMLC), the only professional liability insurer endorsed by MSMS (800-292-1926, or in East Lansing at 351-1150).

MSMS AUXILIARY MEMBERS will meet Oct. 28 and 29 at Kellogg Center, Michigan State University, for a fall educational seminar dubbed "Grand Rounds." The theme spotlights the Auxiliary's new speakers bureau. During the two-day meeting, auxiliary members will begin training for their speaking engagements around the state. Also on the agenda are sessions on management-by-objective, and parliamentary procedure.

THE MICHIGAN BOARD of Medicine will hold a public hearing at 1 p.m. Oct. 29 on the proposed rules and regulations regarding physician licensure by examination. The hearing is scheduled at 905 Southland, Room A, Lansing. Comments may be presented orally, with written copies available to the board, or submitted by mail prior to the hearing.

MICHIGAN PHYSICIANS are asked to telephone local and state public health departments as soon as possible after seeing suspected cases of Reye's Syndrome. The disease is frequently associated with influenza. Its occurrence rises during the cold months. Please contact William Hall, MD, or Ronald Waldman, MD, Division of Disease Surveillance, Michigan Department of Public Health, 517/373-1369.

Legal briefs . . .

On Oct. 21, as this Medigram was being prepared, MSMS received a copy of a motion from the Federal Trade Commission asking the judge's permission for rebuttal testimony in the FTC's case against MSMS. The FTC is alleging MSMS illegally coerced Blue Cross Blue Shield of Michigan. Testimony from both sides has been heard by a federal administrative law judge in Washington and Detroit. If this latest motion is granted, the rebuttal testimony will take place in early November in Washington....The U.S. Supreme Court has affirmed a federal Appeals Court ruling in an important case over minors' rights to contraceptives without parents' knowledge. The Sixth Circuit Court of Appeals in February reversed lower court rulings and declared there is no requirement of parental notice and/or consent before minor children's use of contraceptives. That Appeals Court ruling now stands. The case of Doe vs. Irwin began with a class action suit filed by Ingham County parents against a local family planning center....A Michigan Supreme Court ruling is expected sometime this year in a former Bloomfield Hills physician's countersuit against two attorneys. Seymour Friedman, MD, now of Macomb County, countersued the attorneys' after their client unsuccessfully sued him for malpractice. The case has been winding its way through the court system. MSMS hopes for a favorable outcome for Doctor Friedman, as the medical society filed an amicus curiae brief in his behalf in February, 1979.

MSMS seeks interesting case studies for Annual Scientific Meeting

Many course directors for the MSMS Annual Scientific Meeting Nov. 18-19-20 at the Hyatt Regency Dearborn are requesting case studies from MSMS members who have registered. Samuel M. McMahon, MD, Annual Scientific Meeting chairman, urges physicians who have been contacted to offer their materials for study. There is time yet to register for the 53 half-day courses of the Annual Scientific Meeting, though many are nearly filled and the Advanced Cardiac Life Support Course is sold out again. Registration forms are in the Oct. 9 Medigram.

Michigan State Medical Society
120 West Saginaw Street
East Lansing, Michigan 48823

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Editor: Judith Marr

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CAPSULES

TO STRENGTHEN physician legislative efforts at the "grass-roots" level, the MSMS Committee on State Legislation and Regulations, chaired by W. E. Maldonado, MD, will sponsor a County Medical Society Legislative Committee Workshop Nov. 13 at MSMS headquarters. The Legislative Committee Workshop will provide a forum to discuss current county legislative committee practices; methods for more effective legislator liaison; and the relationship of MSMS legislative efforts and staff to county efforts.

THE MSMS COUNCIL at its Oct. 22 meeting received information on the newly-released report of the Graduate Medical Education National Advisory Committee (GMENAC). The report contains 106 recommendations "to achieve an appropriate number of physicians in each specialty, to assure adequate financing mechanisms for graduate medical education, and to achieve a proper utilization of other categories of complementary manpowers." The report could affect health care delivery for generations, says AMA Executive Vice President James H. Sammons, MD. The GMENAC report forecasts a surplus of 70,000 physicians by 1990. It calls for a reduction in medical school enrollments and for incentives to expand primary care residencies.

National election results sway Michigan to the right

With election returns just in, Michigan physicians were as surprised as the rest of the country at the size of Ronald Reagan's victory in the presidential race. The country's electoral shift to conservative politics had its effects in Michigan, as one of the key "swing" states in the election. The state House of Representatives shifted its balance closer to the Republican side, with that party apparently gaining six seats in the State House. It looks as though 64 Democrats and 46 Republicans will serve the next two years as state representatives. At printing time, Michigan appeared to be gaining one Republican congressman, with James Dunn (R) defeating Robert Carr (D) in the 6th District.

All of the proposals on the statewide ballot were defeated, most notably the tax amendments.

AMA names Doctor Rice recipient of Rush Award

The late Robert E. Rice, MD, beloved and respected MSMS leader and former AMA delegation chairman from Michigan, is the recipient of the AMA's Benjamin Rush award. Doctor Rice, who died unexpectedly July 16, was selected for the award at a mid-October meeting of the AMA Board of Trustees. The award recognizes his outstanding community contributions, citizenship and public service. Doctor Rice was nominated by Carl A. Gagliardi, MD, alternate AMA delegate, and Frank B. Walker, MD, AMA delegate, with the support of the Wayne County Medical Society, MSMS, and the Michigan delegation to the AMA. Mrs. Rice will be flown by the AMA to the San Francisco Hilton Dec. 7 when she will receive a commemorative plaque and \$2,500 during opening ceremonies of the AMA House of Delegates interim meeting.

MSMS has arbitration forms

Forms for Michigan's medical arbitration system are available from MSMS at cost. Agreement forms and booklets for 100 patients are \$10.50. (Other quantities available.) Contact Mrs. Nancy Wimmer, MSMS headquarters, 517/337-1351.

COURSE DIRECTORS, faculty and MSMS staff are readying for the 1981 MSMS Annual Scientific Meeting Nov. 18-19-20 at the Hyatt Regency Dearborn. Final preparations are underway for the three-day Category I meeting, which will offer 53 half-day courses. Interested physicians may register at the meeting by checking at the MSMS registration desk in the Hyatt's Exhibit Hall. As many as 18 Category I credits may be earned. Samuel M. McMahon, MD, Lansing, is general chairman.

THE ATTORNEY GENERAL will seek the revocation or suspension of the licenses of one physician and four chiropractors in the Flint area who falsified disability statements for "patients" who said they needed an excuse for missing work or wanted to collect sickness and disability benefits. The "patients" were, in most cases, reporters from The Flint Journal posing as autoworkers who said they needed an excuse for missing work or wanted time off. The attorney general has filed a complaint with the Board of Medicine against the physician.

MSMS Council Highlights

On Oct. 22 at MSMS headquarters, the MSMS Council:

- 1) Gave high legislative priority to reinstating annual updates of Medicaid reimbursement screens equitable with current Medicare levels. The action was taken after the Department of Social Service requested physicians accept a 15 percent reduction in Medicaid reimbursements effective Dec. 15, on top of no Medicaid screen updates since 1977.
- 2) Referred results of a recent membership survey on group health insurance benefits to the Task Force on Member Insurance Programs. The Council also disbanded the Task Force to Study Alternatives to the 94000 Group Health Coverage, as its task was completed.
- 3) Appointed Frank Cox, MD, Detroit, as chairman of the 1981 MSMS Annual Scientific Meeting.
- 4) Approved the 1980-81 MSMS budget showing \$2,644,751 in projected revenues, and \$2,541,483 in projected expenses. In addition to the projected increased expenditures caused by inflation, this budget reflects increased emphasis on public service, communications, physician education and government relations. In presenting the budget, Dean P. Carron, MD, Finance Committee chairman, commented that any new projects authorized by the House of Delegates or The Council will require a dues increase.
- 5) Supported pending state legislation putting existing Medicaid fraud and abuse control policy into statute, with some MSMS amendments.
- 7) Endorsed most proposed Board of Medicine rules governing clinical academic limited licenses, non-clinical limited licenses and postgraduate educational limited licenses; but voted not to endorse a proposed rule that fails to adequately limit such licenses in hospital practice. The Council endorsed proposed rules on application and examination for full licensure with the stipulation that applicants must pass all three portions of the FLEX in one sitting.

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MICHIGAN MEDICINE

November 1980

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Vol. 79, No. 32



The following AMA Principles of Medical Ethics were adopted by the AMA House of Delegates meeting in annual session July 20-24, 1980. They are designed to be the foundation upon which the opinions and reports of the AMA Judicial Council will be based. They establish broad areas of responsibility for all physicians and emphasize the belief that ethical standards are developed for the benefit of the patient.



AMERICAN MEDICAL ASSOCIATION

Principles of MEDICAL ETHICS

Preamble:

The medical profession has long subscribed to a body of ethical statements developed primarily for the benefit of the patient. As a member of this profession, a physician must recognize responsibility not only to patients, but also to society, to other health professionals, and to self. The following Principles adopted by the American Medical Association are not laws, but standards of conduct which define the essentials of honorable behavior for the physician.

- I. A physician shall be dedicated to providing competent medical service with compassion and respect for human dignity.
- II. A physician shall deal honestly with patients and colleagues, and strive to expose those physicians deficient in character or competence, or who engage in fraud or deception.
- III. A physician shall respect the law and also recognize a responsibility to seek changes in those requirements which are contrary to the best interests of the patient.
- IV. A physician shall respect the rights of patients, of colleagues, and of other health professionals, and shall safeguard patient confidences within the constraints of the law.
- V. A physician shall continue to study, apply and advance scientific knowledge, make relevant information available to patients, colleagues, and the public, obtain consultation, and use the talents of other health professionals when indicated.
- VI. A physician shall, in the provision of appropriate patient care, except in emergencies, be free to choose whom to serve, with whom to associate, and the environment in which to provide medical services.
- VII. A physician shall recognize a responsibility to participate in activities contributing to an improved community.

Do you know

a physician
with problems
of alcoholism,
drug abuse,
or other
difficulties
which interfere with
his/her abilities
to practice medicine?

*If so, please contact
your MSMS Committee to
assist Impaired Physicians
through Marce Ireland at MSMS
headquarters (517) 337-1351.*





Doctors' and nurses' professional relationships are the theme of this month's special report, beginning on page 562. (Photo by Mert Scholten, MSMS staff, of members of Ingham Medical Center medical and nursing staffs.)

MICHIGAN MEDICINE

November 1980, Vol. 79, Number 32

Special report

- 562** The shortage of nurses, the education of nurses and the scope of the nursing profession are major issues bubbling in the stewpot of health care delivery these days. Each of the issues has major impact on how the health care team works. The opinions vary widely on what should be done to resolve the problems, and even on what the problems are. Physicians' views are split on the issues, as seen by columns written in this issue on pages 558 and 566. Thus, in this issue, we describe the issues, the latest developments, including MSMS' own actions, and allow spokesmen for various sides to present their views; MSMS Task Force on Nursing, Nadine Furlong, RN, MS, and H. Richard Henderson, MD

Features

- 568** Michigan Joint Practice Commission seeks identity of physicians and nurses who have joint practice arrangements
- 570** Legislative profile: Sen. R. Robert Geake; Willah Weddon
- 572** MSMS long-range planning retreat turns into an advance; John R. Ylvisaker, MD
- 575** Refugee report: The cultural backgrounds and public health aspects of Michigan's Indochinese refugees; Maurice S. Reizen, MD
- 592** MSMS seeking new legislation to mandate Medicaid peer review system; Ellen Vinocur Potash
- 595** Michigan Board of Medicine disciplinary actions

Departments

- 558** In my opinion; Harvey M. Andre, MD
- 559** Letters
- 561** MSMS/A; DeLourde LaVielle
- 582** Peer review exchange; Robert Medlar, MD
- 587** MSMS Q/A
- 588** Health planning update
- 598** New members
- 602** Meetings
- 604** Category I meetings
- 606** Deaths
- 608** Classified ads
- 609** Ad index
- 610** President's page; James D. Fryfogle, MD

The nursing profession and medical practitioners

By H. M. Andre, MD, Grand Rapids



Marvelous strides have been made in the nursing care of ill patients, in hospitals, in the last few decades. Certainly today's well-educated nurse (RN) has a much broader knowledge of the illnesses and injuries suffered by the patients under her care than her counterpart had 20 or 30 years ago. In the event of a cardiac arrest, today's well-trained nurse can proceed immediately with resuscitative measures with a quick application of CPR techniques and medications, which undoubtedly have saved many lives. By the time the doctor arrives at the bedside, proper treatment has already begun.

No one can argue the point that our nurses have far greater knowledge and abilities than their predecessors.

However, how far in total patient management should nurses proceed? Some years ago there was a great hue and cry about the shortage of doctors, and it was the popular thing to advocate nurse practitioners as the answer to the shortage. The medical profession raised no formal objection and did not formulate a plan as to how far such a practitioner should go.

As a result, today we have an American Nursing Association program advocating that all nurses entering the profession by 1985 should have a bachelor's degree.

There is no question but that we do need people with degrees to teach and supervise, but do we need this academically-oriented type to provide good, personal, loving care to an ill patient?

Patricia Harris now says that we will have 70,000 excess doctors of medicine in the United States by 1990, some 145,000 excess doctors by the year 2000. Do we need to have "highly trained" nurse practitioners to augment this excess of available medical care? The statement is made that these nurses can provide medical care in such settings as federal low-income housing, home care dying patients, store-front health assessment clinics. Are we going to have first-rate and second-rate care for our citizens?

I do not believe this problem can be taken lightly. We do need nurses who know how to handle emergency situations. We do need nurses who know enough about disease to make a presumptive diagnosis in their own minds, but they should call in a physician to make the diagnosis and prescribe treatment. A doctor of medicine has gone to medical school plus postgraduate training and background, but the nursing education programs do not and should not provide all this educational background.

We need nurses for round-the-clock care of patients. We need nurses who can provide patient comfort, be alert to emergencies, and know when to call for expert medical help. I believe we do not need bachelor degree nurses to practice medicine.

The opinions expressed on this page are those of the author, and do not always represent Michigan State Medical Society policy.

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Michigan Medicine, the official journal of the Michigan State Society, is dedicated to provide useful information for Michigan physicians about actions of the Michigan State Medical Society and contemporary issues, with special emphasis on socio-economics, legislation and news about medicine in Michigan.

The Michigan State Medical Society Committee on Publications is the editorial board of Michigan Medicine and advises the editors in the conduct and policy of the magazine, subject to the policies of the MSMS Council.

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"We now recommend removal of Dalkon Shield from all (users)"

Domestic distribution of the Dalkon Shield by the A. H. Robins Company was discontinued in June 1974. Subsequently, we have concurred with the majority of medical opinion relative to IUDs in suggesting that women who continued to use the Dalkon Shield without problems or difficulties need not have it removed.

At the same time, we have followed the medical literature regarding, among other possible IUD-associated complications, the relative risk of pelvic inflammatory disease among IUD-users compared to non-users and, lately, the relationship, if any, between duration of IUD use and pelvic infection.

The medical literature does not establish a firm relationship between the duration of use of inert IUDs and an increased risk of pelvic infection generally; but a relationship has been suggested by recent literature, particularly when the causative organism is *Actinomyces israelii*. Cases of pelvic actinomycosis which cannot be explained on the basis of direct extension from the gastrointesti-

nal tract have been observed most commonly among long-term IUD users.

Actinomyces israelii is an anaerobic, gram-positive bacterium which forms mycelia that may fragment into bacillary and coccoid forms. The organism is difficult to culture. Identification is most often made on the basis of immunofluorescence, special stains, or a finding of typical "sulfur granules" in the involved tissues.

Pelvic actinomycosis is usually insidious in onset and clinical symptoms may be absent until a pelvic mass is noted on examination. By this time, advanced disease of the tubes, ovaries or uterus may be present. The infection has been reported in users of a variety of IUD types. Recent reports have indicated that the problem can be minimized by replacing inert IUDs at periodic intervals, generally not exceeding three years. [Schmidt, W.A., et al. "Actinomycosis and intrauterine contraceptive devices — The clinicopathologic entity" Diagnostic GYN and OB II (3) 165-177 (Fall) 1980 (in press) Duguid, H.L.D.; Parratt, D.; Trynor, R. "Actinomyces-like organisms in cervical smears from women using intrauterine contraceptive devices" Br. Med. J. 281 (6239) 534-37 (Aug. 23) 1980.]

Since any present users of the Dalkon Shield are in the long-term use category, we now recommend removal of this IUD from any of your patients who continue to use it, even though they may not be experiencing any pelvic symptoms at this time. We further suggest that the removed IUD and adherent material be submitted to a clinical pathology laboratory for examination for organisms consistent with actinomycetes. If present, the patient should be carefully followed and, where clinically indicated, appropriate therapy administered.

Fletcher B. Owen, Jr., MD, PhD
Director of Medical Services
A.H. Robins Company
Richmond, VA

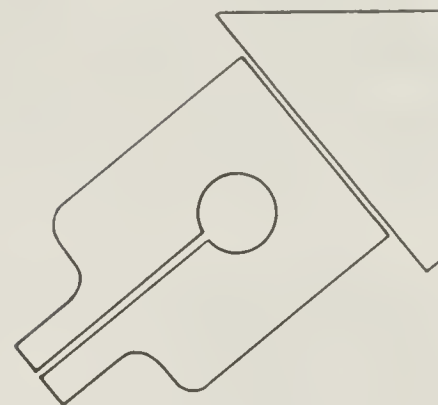
"... get involved in politics ..."

Just happened to notice my picture on page 460 of the August issue of *Michigan Medicine*, where it states I was an alternate delegate to the Republican Convention.

I would like to correct your statement, as I was not a delegate to the convention. However, we did entertain all the Michigan delegates at a cocktail party at our home on Monday afternoon at the beginning of the convention.

I would encourage all doctors and their wives to get involved in politics, as that is the only solution to our problems.

Richard E. Straith, MD
Southfield



The governor thanks Michigan MDs for gifts to refugee relief fund

The following letter was addressed to MSMS Council Chairman Louis R. Zako, MD, Dearborn Heights:

I wanted to take this opportunity to thank you for your personal commitment to my efforts to raise money to aid Cambodian refugees. As you know, following my trip to Thailand to tour refugee camps, I was greatly disturbed by the conditions of the refugee camps, by the sight of men, women and children dying of disease and starvation. Since returning we have had a good response from the citizens of Michigan and we are doing everything we can to help in a bad situation.

Jim Jordan has described to me your enthusiasm and the help you have given to the fund-raising effort and I really appreciate all you are doing. I've just finished reviewing the first copy of the Michigan Medical Society's journal which talks about the refugee problem. It is a very fine article and I look forward to reviewing the coming issues.

Thank you again for your help in this most important matter.

Kind personal regards.

Sincerely,

William G. Milliken
Governor, State of Michigan

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Ensures smooth therapeutic effect even if a dose is missed The relatively longer half-life of Valium® (diazepam/Roche) has important clinical and pharmacological implications. Steady-state levels generally are reached within 5-7 days with no further accumulation. At this plateau, the patient benefits from the consistent, steady response you expect. Sharp blood level variations, frequently attributed to agents with a short half-life, do not appear with Valium.

Avoids sudden symptom breakthrough

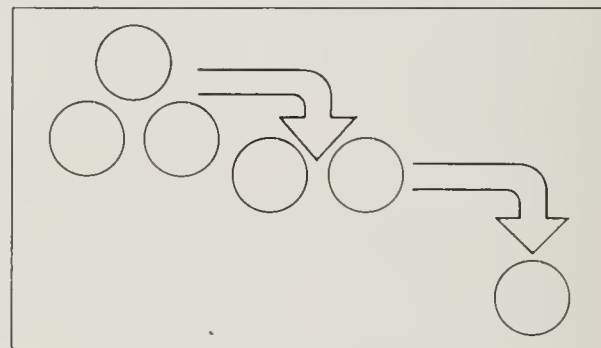
Once steady-state levels are achieved, sudden reemergence of symptoms is unlikely. Diazepam and its active metabolites exhibit overlapping half-lives that are advantageous not only during therapy but especially when pharmacologic support is discontinued. Elimination rates are gradual with Valium and thus provide a compatible adjustment interval for

the patient. In comparison, blood levels of short-acting agents with inactive metabolites decrease more rapidly and are more likely to be associated with withdrawal symptoms if medication is stopped abruptly.* With Valium unwanted effects other than drowsiness or ataxia are rare. Patients should be cautioned about driving and advised to avoid alcohol.

Tapers naturally; complements gradual dosage reduction at discontinuation

When any psychoactive medication is discontinued, it is good medical practice to gradually reduce the dosage. From your own experience you know this is rarely necessary after a short course of Valium therapy, but for patients on extended therapy, gradual reduction of dosage is advisable. This regimen, along with the self-tapering feature of Valium, provides a smooth transition to independent coping.

*Sellers EM: *Drug Metab Rev* 8(1):5-11, 1978



*in the management of
symptoms of anxiety*

Valium®
diazepam/Roche
2-mg, 5-mg, 10-mg scored tablets

*effective therapy through
efficient pharmacodynamics*

Before prescribing, please see summary of product information on next page

ROCHE®

Valium®
diazepam/Roche

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Management of anxiety disorders, or short-term relief of symptoms of anxiety, symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal, adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, atetosis, stiff-man syndrome, convulsive disorders (not for sole therapy)

The effectiveness of Valium (diazepam/Roche) in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma, may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication, abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms similar to those with barbiturates and alcohol have been observed with abrupt discontinuation, usually limited to extended use and excessive doses. Infrequently, milder withdrawal symptoms have been reported following abrupt discontinuation of benzodiazepines after continuous use, generally at higher therapeutic levels, for at least several months. After extended therapy gradually taper dosage. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed, drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported, should these occur, discontinue drug. Isolated reports of neutropenia, jaundice, periodic blood counts and liver function tests advisable during long-term therapy.

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MSMS IA

Doctor — is your spouse an auxiliary member?

By DeLourde LaVielle, Flint



Doctor — Is the spouse in your house a member?

A member of the Michigan State Medical Society Auxiliary, that is. A strong auxiliary membership can benefit you as well as your spouse.

Membership entitles your spouse to associate with one of the most constructively-involved organizations in your community, to improve the health care and medical practice by influencing legislation, and to receive "Facets," the AMA Auxiliary magazine for and about physicians' spouses and the "Auxilium," an eight-page state publication. This is the official state communique and it is mailed to each member. It includes county, state and national auxiliary news.

Auxiliary members are better informed. An annual Legislative Day is held in Lansing each spring offering an overview of all pending medical legislation plus an opportunity to meet and discuss these issues with state legislators. In the event of a crisis concerning health care delivery legislation, auxiliaries, alerted by a telephone chain can contact their legislator and make their views known.

Auxiliaries are active in the field of health education in the schools with representatives to both the Michigan Health Council and the Michigan Department of Public Health.

The state auxiliary promotes programs dealing with physical fitness, immunization, highway safety and physician impairment. Programs sponsored by individual counties within the state deal with child passenger safety, scoliosis screening, scholarships and loans, teenage pregnancy, CPR training, mobile meals and an illness guide for parents of school-age children.

Our members join us because they believe in what we do; because they can be of service; because they appreciate the contacts and companionship; because they keep informed; because they can work to correct unfair legislation; because interested active people belong.

It doesn't cost to belong — it pays!

Help your spouse get in on the benefits and start reaping the rewards, Doctor. We know that one person can make all the difference in whether or not things get done.

Just one person. Your spouse!

Mrs. LaVielle is membership chairman, Michigan State Medical Society Auxiliary.

Communication must be open today between physician and nurse



The following article is published under the auspices of the MSMS Task Force on Nursing, chaired by Charles L. Seifert, MD, Battle Creek.

You've heard it. We've all engaged in it.

The talk about nurses has been increasing in decibels. The confusion of opinions, facts and issues has been growing with the noise of voices raised.

MSMS has joined the discussion with its recent establishment of a Task Force on Nursing, passage of position statements on joint practice and nurse midwifery, and support of state recommendations on nursing requirements and resources for 1985-1990.

It's time for a serious appraisal of the situation, for clearing the air, for working together to solve the problems.

What are the issues?

Nursing shortage

First, there is a generally agreed-upon shortage of nurses.

"The nurse shortage is here," declared the spring issue of the Michigan Health Council's "Good Health Advocate" newsletter. "Michigan is feeling the shortage."

According to the "Advocate," national unemployment figures for nurses have been under two percent for the past five years. Few figures are available on actual numbers and types of nurses working.

The definitive study to date in Michigan is the Office of Health and Medical Affairs' just-published "Report on Nursing Requirements and Resources for Michigan 1985-1990." The report's 10 recommendations call for better data, and actions to in-

crease the numbers of working nurses in Michigan.

The Michigan Hospital Association board of trustees earlier this year voted top priority to developing strategies to address issues related to the supply of hospital nurses.

"An acute nursing shortage has the potential to set the health care community and the consuming public on its ear in the 80's, just as soaring medical costs and inflation did during the seventies," says the Omaha Methodist Hospital's spring issue of its "Pulse Beat" newsletter.

A contributor to the October, 1980, *Michigan Hospitals* magazine, qualifies the shortage of nurses, however. Patricia Munshaw, president, Michigan Society of Hospital Nursing Administrators, cites a National League for Nursing survey which notes the variation in demand for nurses is great.

And there are some who believe there is not really a shortage of nurses. It's just a problem of distribution, they say, echoing comments made when problems of a "physician shortage" were raised a decade ago.

The maldistribution problem has been around a long time, they say.

Paul Shaheen, assistant director of government affairs for the Michigan Hospital Association agrees, "The issues have been bubbling for some time." He reported in the MHC "Advocate," however, that the nursing shortage in Michigan has reached a crisis stage.

Various sources attribute the nursing shortage to decreasing numbers of high school seniors; increasing demand for nursing care; increased technology, with its greater pressures for knowledge; and nursing school turmoil over which system of nursing education is best suited for entry level technical or professional nursing.

Social changes which have broadened women's career choices contribute and so do professional changes which have enormously broadened the need for nurses to provide the type of nursing care expected and needed by patients. Other factors, according to the Michigan Health Council's "Advocate," are more stringent requirements for

foreign-trained nurses wishing to work in the US; increasing employment in community health, health education and other non-traditional settings, and the growth of privately-operated nurse employment services.

"The nurse shortage has to be addressed both in initial employment and retention," declares Nadine Furlong, executive director, Michigan Nurses Association. (Her thoughts in greater detail appear elsewhere in these pages.)

Educational routes

Another major issue these days is debate over their education.

MSMS Council Chairman Louis R. Zako, MD, observes:

"Entry into practice is the single biggest problem seen by the Michigan Nurses Association and American Nurses Association. They want to upgrade qualifications for nurses and decide what types of nurses may practice.

"The highest calling of a profession is to upgrade the professional background of their members," Doctor Zako says in support. "But it may be that the nurses are moving too fast. I think most people don't understand the difficulties involved."

Currently, licensed nurses enter the profession through four educational routes:

1) Licensed practical nursing courses of approximately one year at community colleges, senior colleges, hospitals and adult education programs.

2) Diploma programs of three years operated by hospitals.

3) Associate degree programs of two years at community colleges, and

4) Baccalaureate degree programs of four years at senior colleges and universities.

"The educational shift, nationally and in Michigan," says the Health Council, "has swung to the community college which confers the ADN degree." From 1975 to 1977, 45 percent of Michigan's graduating nurses received associate degrees, 31 percent received diplomates, and 23 percent baccalaureate degrees.

Nurses with diplomas still account for more than 50 percent of the RNs now active in the state, says the MHC "Advocate," though their numbers and the numbers of schools

Recent MSMS actions regarding the nursing profession

April 9, 1980 — MSMS Council approved a preliminary joint statement on nurse midwifery developed by the MSMS Committee on Maternal and Perinatal Health and by The Michigan Chapter, American College of Obstetricians and Gynecologists. The Council authorized transmittal of the joint statement to the Board of Nursing and the Nursing Specialty Task Force.

April 11 — MSMS Council approved the statement on joint practice found elsewhere in this issue. (See page 568)

April 25 — MSMS Council appointed a new MSMS Task Force on Nursing, comprised of Charles L. Seifert, MD, Battle Creek, chairman; Louis E. Heideman, MD, Birmingham, and H. Richard Henderson, MD, Warren.

Sept. 5 — MSMS Council supported recommendations of a report, "Nursing Requirements and Resources for Michigan 1985-1990," commissioned by the Michigan Office of Health and Medical Affairs. The Council questioned the validity of the data used, but generally supported the OHMA report's recommendations by stating that articulation between LPNs and associate degree (AD) nursing programs and between AD and bachelor of science nurse (BSN) programs be given top priority, that diploma nursing programs should not be closed until an adequate supply can be guaranteed, and that there should be a standing committee appointed to continually assess the needs of nurses with programs established to assure an adequate supply of nursing personnel to meet the needs of the state.

November, 1980 — MSMS Council is studying guidelines for hospital nursing privileges for nurses not employed by a hospital.

SPECIAL REPORT/continued

which train them are dropping. There are only eight diploma schools operating in Michigan today.

In 1978, the ANA House of Delegates called for two categories of nursing practice to be clearly identified and titled by 1980 — "professional" and "technical." By 1985, the ANA said, the baccalaureate degree should be declared the minimum preparation for entry into professional nursing.

In December 1979, the Michigan Nurses Association House of Delegates also approved a position paper supporting the baccalaureate entry level for professional nursing, and the associate degree for all other nursing. There would be separate licensing exams and sets of competencies. LPNs would be encouraged to move into RN educational programs and RNs into the baccalaureate programs.

The MNA, however, does not adhere to the 1985 time line for change. It supports change through cooperative and voluntary means in the decade 1980-1990.

Licensed practical nurses strongly oppose the ANA's 1985 goal. The Michigan Licensed Practical Nurses Association maintains that such a change would result in fewer practitioners, more costly education, higher health care costs, and practitioners less prepared than currently to function in direct patient care duties.

Scope of practice

The scope of nursing practice is the third major issue involving the nursing profession today in Michigan, and it is the one which perhaps strikes closest to the hearts of Michigan physicians.

"Are nurses getting uppity?" is the headline of a recent special feature in *Cincinnati Medicine*. "In the past 20 years there has been a growing interest in the importance of the physician-nurse relationship to patient care," writes George Russo, MD, president, medical staff, Cincinnati Good Samaritan Hospital, in that issue. "It is common knowledge that this interprofessional relationship is undergoing stresses and strains."

Nurses are expanding their roles, becoming nurse practitioners, nurse

clinicians, nurse-midwives, nurse-anesthetists, intensive and coronary care nurses, and entering joint practice with physicians.

Section 17210 of the new Michigan Public Health Code stipulates that, "The Board of Nursing may issue a specialty certification to a registered professional nurse who has advanced training beyond that required for initial licensure and who has demonstrated competency through examination or other evaluation processes and who practices in one of the following health professional specialty fields: nurse midwifery, nurse anesthetist, or nurse practitioner."

A Nursing Specialty Task Force has drafted the administrative rules for the implementation of Section 17210. The rules are now undergoing the public hearing process and will be officially put into effect by the Michigan Board of Nursing.

The debate rages over how much responsibility nurses may have in their expanded roles and of how much their duties could overlap those of physicians.

MSMS actions agreeing to nurses' enlarged roles have been carefully couched to delineate boundaries of responsibility.

The statement on joint practice passed this spring by the MSMS Council declares that "medical and nursing services are complementary but they are not interchangeable either in responsibility or accountability."

Other medical associations have made careful clarification of roles.

The American College of Obstetricians-Gynecologists in 1978 reaffirmed its policy that the health care team "necessary to provide optimal maternity care must be guided by a qualified obstetrician-gynecologist."

The American Academy of Family Physicians policy regarding family nurse practitioners is thus:

"Because the AAFP does not believe that the independent nurse practitioners are trained to provide comprehensive care, the AAFP does believe that the expanded role of the family nurse practitioner in family practice should always involve functioning as part of a health care team which includes at least one family physician. The family nurse practitioner should not function as

an independent health practitioner. The family nurse practitioner should not be employed as a means of providing comprehensive care except under the direction and responsible supervision of a practicing, licensed family physician with all reimbursement for services being through the responsible supervising physician."

Forthcoming rules

All parties are awaiting the state's forthcoming rules and regulations guiding nurse-anesthetists, nurse-midwives and nurse-practitioners.

Some physicians grumble that nurses are "trying to become doctors." One of the ironies of our time, others observe, is that while paramedics seem to be moving ahead, physicians are being restricted. "However," observe still other MDs, "medical systems are all set up for physicians to bail out other medical professionals in a crisis. Physicians must assume the medical responsibility for all who lay their hands on patients."

Counters Doctor Zako, who has been in joint practice for six years with his wife, Mary Zako, RN, a nurse practitioner:

"Many people who don't understand the role of nurse clinicians get all hung up on nurses making independent judgments without the doctor's blessing. But what about doctors making judgments? What about a general practitioner making a surgical judgment without a surgeon's help? What about an internist making a psychiatric decision without involving a psychiatrist? There should be a sharing between professionals on important decisions on all levels. Ideally, the lines of communication between nurses and doctor should be as easy and open as between doctor and doctor."

The range of issues, opinions and statistics is wide. The solutions to the problems and the future situation are not known. It is certain, however, the dialogue has begun. It must continue if all parties wish to assure a satisfactory outcome.

Nursing in same situation today as medicine after Flexner report

By Nadine Furlong, RN, MS, East Lansing

Multiple issues face nursing today. Many of the issues affecting nursing have a direct or indirect effect on physicians. We must work together during this decade to achieve mutual goals, quality health care delivery and quality patient care.

A major issue facing nursing today is the reorganization of its educational programs into a coherent system of education preparation for entry into two categories of nursing practice.

Medicine faced this dilemma in 1910 with the Flexner report, which heavily criticized the medical education system. By 1920 medicine had established medical education as a university discipline with definite educational standards and a minimum of educational preparation for entry into the profession. This is essentially what nursing is now proposing.

Coherence lacking

Nursing has experienced four similar national reports on the lack of coherence and order in the nursing educational system since 1923 (Goldmark 1923, Burgess 1934, Brown 1948, and Surgeon General 1963).

In 1965 the American Nurses Association published a position paper on minimum educational preparation for entry into professional nursing practice. The two categories of educational preparation for entry were identified as the Associate Degree in Nursing and the Baccalaureate Degree in Nursing.

This position was reaffirmed with three resolutions at the 1978 ANA House of Delegates, where the so-called "1985 resolution" was passed. This resolution called for the establishment of the Associate Degree in Nursing and the Baccalaureate

ate Degree in Nursing as basic entry into the practice of nursing by 1985. By setting the date, ANA attempted to mobilize nursing to make active strides toward this goal identified in 1923 and a formal position of the Association since 1965.

Michigan is experiencing enough social, economic, political, educational, and professional forces to accomplish this objective on a voluntary basis during this decade.

Nursing strongly believes that with the increasing complexity of care due to knowledge and technological advances, educational preparation of nurses must take place in institutions of higher education.

With hospital patients more acutely ill and ambulatory care more frequent, the RN today needs a knowledge base more extensive than in the past to make independent clinical judgments in a variety of settings. This increased preparation can be of benefit to physicians, as nurses share more of the responsibility for patient care.

A second issue requiring action in this decade is competency for licensure. MNA has published a position paper on competency and is currently in the process of re-submitting a grant proposal on this issue to the Division of Nursing, U.S. Department of Health and Human Services.

Michigan faces a 1984 implementation deadline for competency measures for all health occupations; this is a mutual concern of most health professionals. Specialty certification is of current interest to nursing as administrative rules are being promulgated to implement the Public Health Code. The professional association maintains an active role in providing testimony and monitoring this and other legislative activity.

Third party reimbursement is also of concern to nursing. Nursing care is inappropriately lumped together with room and board in hospital costs; this is offensive to nursing. Organized nursing service must be



recognized as an identifiable cost if true accountability is to occur.

Additionally, individual reimbursement of master's degree prepared qualified nurse practitioners must be equitable with reimbursement of those with masters degrees in other disciplines, such as social work. Third party reimbursement will be carefully monitored by the profession in this decade as nursing continues its vital role in health care delivery.

Sufficient staffing

A major area of activity in nursing today is the use of collective bargaining as a means to achieve implementation of professional standards of practice, equitable compensation commensurate with professional responsibilities, and reasonable working conditions that enhance the practice of nursing. It is through this program that another major issue is raised; that of hospital staffing and pooling of RNs between unrelated units. The issue of adequate, prepared registered nurses to provide sufficient staffing is one area where dialogue between MDs and RNs can begin.

It is important to note the changing nature of nursing. Nursing developed out of military and religious orders where obedience, compliance and dependence were rewarded. Presently, nursing expectations include autonomy and competence, accountability and clinical judgment. Many nurses feel trapped in this transition — being trained in one

Ms. Furlong is executive director of the Michigan Nurses Association.

continued on page 566

MSMS Task Force can work for understanding and support

by H. Richard Henderson, MD, Warren



For a number of years (has it been more than six?) I have been a member of the Michigan Joint Practice Commission. It is with this special perspective that I was recently appointed a member of the MSMS Task Force on Nursing.

My interest is in the expanded role of the nurse, particularly, in ambulatory care. It is my feeling that nurses and physicians working together in the ambulatory setting can provide, with their complementary skills, much more toward the care of the patient.

If I had to pick one word that might keynote the issues I am most familiar with in this setting, it would be understanding. With understanding, issues are generally minor and easily resolved. Certainly this appears to be the case in many traditional settings where the role of the nurse is clearly understood. On the other hand, with less understanding, issues become major and are not easily resolved.

For example, as physicians, where is our level of understanding on the expanded role of the nurse in the ambulatory care setting? How well do we understand that the nurse in this setting is a professional with unique and valuable skills and is not in competition with the physician? And, finally, how well do we understand that nurses and physicians working together can provide much

more in patient care — care that deals with the patient's health and total being as well as his/her heart disease or kidney disease?

For the sake of discussion let us assume there is satisfactory understanding and even agreement on the expanded role of the nurse. If this be so, the next step, in a word would be to support.

Support from physicians is needed on a number of important issues. One is third party, or some party, reimbursement for nursing services. Another is hospital privileges for nurses. A third is in the area of legal restrictions on nursing practice. A fourth is in the area of patient perception or lack of perception of nursing services. A fifth issue is the need for expanded graduate school education for nurses. A sixth is interdisciplinary education. And there are more.

I see the Task Force on Nursing coming to grips with these issues on nursing practice in the ambulatory care setting. But there are other issues in a variety of settings that should be on the Task Force agenda. Certainly, as members we need to become more informed on nursing issues in general. In the process we should work closely with the Michigan Nurses Association.

Finally, the charge of the Task Force on Nursing is to provide recommendations for MSMS Council action. Hopefully the work of our committee and the action of The Council will result in more understanding and support for a variety of nursing issues and will re-affirm the fact that when physicians and nurses work together, the quality of patient care is greatly enhanced.

Doctor Henderson is a member of the MSMS Task Force on Nursing and is chairman of the MSMS Liaison Committee to the Michigan Joint Practice Commission.

MS. FURLONG/continued

mode and being expected to perform in a different mode. Likewise many physicians cling to past ways of relating, in a new era where old behavior patterns simply don't work.

What can be done? We can evaluate our present ways of resolving conflict between physicians and nurses and select more effective strategies to interact and interrelate.

We can choose to compromise and collaborate rather than avoid, accommodate, or compete. We can analyze our actions and make decisions consistent with mutual goal achievement.

We can form ad hoc committees of RNs and MDs in our settings. We need informal as well as formal dialogue, we need outside speakers in our groups to provide current information on issues. We need a sharing without exploitation by physicians or withdrawal by nurses.

Can this be done? Yes. We must move cautiously, but we must move into the '80s with an awareness of history and a willingness to be risktakers — to chart new courses together in the future.

Health care delivery fellowships available

The Hospital Research and Educational Trust (the Trust), an affiliate of the American Hospital Association (AHA), will award nine fellowships totaling \$108,000 in 1981 to persons who will conduct problem-solving projects aimed at identifying and achieving improvements in the organization and delivery of health care.

Two Edwin L. Crosby Memorial Fellowships and seven W.K. Kellogg Foundation Fellowships of \$12,000 each will be used to support nine-month projects.

Application forms and further information are available from the Hospital Research and Educational Trust, 840 North Lake Shore Drive, Chicago, Illinois 60611. Deadline for receipt of completed applications by the Trust is December 1, 1980. Awards will be announced on March 16, 1981. Fellowships may begin as early as April 1 but must begin no later than September 1, 1981.

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They're in their late sixties, the beneficiaries of more liberal retirement laws and more enlightened attitudes toward the elderly. They're leading socially productive lives. But recently, without any clear cause, they had each begun to experience mild episodes of symptoms such as confusion, mood-depression, and dizziness. Their ability to function could have been jeopardized. That's when they became the beneficiaries of oral Hydergine therapy.



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The MSMS Council this year approved the following statement on Joint Practice proposed by the Michigan Joint Practice Commission.

The document is a statement of purpose and aims of the joint practice concept. It endorses the foundational purposes of the MJPC and sanctions its existence to pursue its goals.

A decade ago, the American Medical Association and the American Nurses Association established the National Joint Practice Commission, to make recommendations concerning the congruent roles of the physician and the nurses in providing quality health care. The Michigan State Medical Society and the Michigan Nurses Association, following the lead of their national counterparts, created the Michigan Joint Practice Commission in 1972.

The Michigan Joint Practice Commission is comprised of active practitioners of medicine and nursing, working together to advance the efforts and educational activities of joint practice.

Physician representatives on the MJPC are Robert R. Carpenter, MD, Inta J. Ertel, MD, both of Ann Arbor, and H. Richard Henderson, Warren.

Statement on Joint Practice

This statement embodies guiding principles and professional opinion on elements of joint practice by physicians and registered nurses in any setting. The authority of the statement testifies to mutually agreed-upon principles of practice. The statement can be used to validate generally acceptable practices or patterns of care and to respond effectively and responsibly to new needs and methods of providing care.

- The health and best interest of the recipients of care are foremost considerations in all practice arrangements.

- The degree of professional re-

sponsibility vested in the physician or registered nurse is related to education, experience, competence, and licensure. Each practitioner should perform only those acts for which that person has been prepared and has demonstrated ability to perform.

- Medical and nursing services are complementary but they are not interchangeable either in responsibility or accountability. Each practitioner is accountable and responsible for the quality of care rendered. Each practitioner is responsible for the maintenance and improvement of practice proficiency.

- Each practitioner should receive remuneration commensurate with qualifications and proficiency.

- Medical and nursing collab-

oration includes both independent and cooperative decision-making. Mutually developed protocols can clarify shared responsibilities and delegated functions.

- Educational programs for the preparation of nurses and physicians in interdisciplinary practice should be developed by the respective professions in consultation with other disciplines as appropriate and should be carried out, whenever possible, under the aegis of accredited educational institutions.

- It is advantageous to have physicians and registered nurses on joint practice committees in order to provide both with an organizational base, a collegial advisory group, and a channel of communication.

- In each health care delivery setting involving the practice of registered nurses and physicians a joint practice committee should establish written policies and standards of performance. Such policies and standards should be reviewed and advanced periodically.

- It is important to maintain a flexible and innovative approach in the evolving role realignment of registered nurses and physicians. Differences in recipient populations, in how they are served, and in the composition of practitioners working in a setting, will influence what each practitioner regularly does.

Are you in joint practice setting?

The MICHIGAN JOINT PRACTICE COMMISSION (MSMS is a member) is seeking to identify physicians and registered nurses currently in joint practice. Those identified will be placed in a directory and/or reference listing to allow the MJPC to better correspond with them and in-

clude them in conferences. If you are in joint practice and wish to be so identified in the directory, please complete the form below and return to MSMS, Box 950, East Lansing, 48823.

Name: _____ (Please print) Phone number: _____

Mailing address: _____

Practice setting: _____ Private office _____ Hospital _____ Clinic _____ Other _____
(Please specify)

I am currently in joint practice with _____

(Please list MDs and RNs): _____

I wish to have my name added to the MJPC directory: _____ Yes _____ No

Signature: _____



"EVERY AGE HAS ITS PLEASURES,
ITS STYLE OF WIT, AND ITS OWN WAYS."

--from *The Art of Poetry* (1674) by Nicholas Boileau-Despréaux

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Sen. Geake has deep interest, power in health care field

By Willah Weddon, special to Michigan Medicine



Sen. Geake

State Senator R. Robert Geake (R-Northville) attributes his entry into politics to his "particular interest in the fields of mental health and special education." He feels his background in the mental health field has helped him be a more effective lawmaker.

Since his arrival at the Capitol as a representative in 1973, through his re-election for two more terms and election as a senator in March, 1977, the psychologist has extended these concerns to virtually all medically-related legislation.

Highlights of these efforts have included his role in formulating and passing the Revised Mental Health Code and the Public Health Code, introduction of his "Fifth Pathway" bill and his present membership on the Special Joint Legislative Committee on Hospital Bed Reduction.

Mental health improved

"The whole mental health picture has improved in many ways," the senator observes. He concedes, though, there is still room for improvement. The same people are employed at the Plymouth Center for Human Development in Northville, he says, although investigators ver-

ified reports of patient abuse more than two years ago.

"That's not because we wanted to keep them," he says, "but because the State Department of Civil Service and its hearing officers reinstated them.

"The Plymouth Center superintendent, William Womack, MD, was reassigned to a different area. But many of the people who cared for children on the wards are still acting in the same capacity."

Geake is disturbed by the understaffing of state mental health facilities caused by lack of state funds. "Howell's Hillcrest Regional Center for Developmental Disabilities is shamefully understaffed," he says. "The court order for Plymouth Center has mandated such a full staff that other facilities have been understaffed.

"Doctor Ochberg (Frank M., MD, director, Michigan Department of Mental Health) is concerned but he's under a court order and would have to have more state funds to add more staff."

The 44-year-old Sen. Geake (born Oct. 26, 1936) has a PhD in psychology. He was supervisor of outpatient psychological services at the Plymouth State Home and Training Center at Northville. Here he later served as director of the psychology department and then director of programs until he resigned in July 1969 to enter private practice as a consulting psychologist.

During 1969 Geake was chairman of the Mental Health Subcommittee of the Governor's Task Force on Health and Mental Health. Then followed his election to public office. During his first term of office the Mental Health Code was passed.

He served on the Public Health Statutes Revision Project, where he was involved in the "scope of practice" aspect of revising the Public Health Code. "I worked on all these problems . . . mediated with MA and PhD-level psychologists, physicians

and para-medics, dentists and dental assistants and dental technicians, physicians and chiropractors, and the dispute among about five different kinds of nurses.

"I tried to bring them all together so we could have a code, and it worked out fairly amicably," he continued. "The only people who seem to be really unhappy now are the social workers who thought they should be licensed as health providers."

Concerning the roles of the Department of Licensing and Regulation, and the Michigan Board of Medicine under the new Code, Geake takes a philosophic view. "Their differences have to be resolved in the overall context of the Department's current efforts to achieve dominance over the various boards.

"I think there's no question but what the Department would like to have fewer licensing boards . . . and would like those boards to have less of a role in the day-to-day licensing and regulation of the various professions."

On Appropriations Committee

In addition to serving as Assistant Minority Floor Leader, Geake is a member of the Senate Appropriations Committee which is increasingly powerful during the current budget squeeze.

He said for the first time the Appropriations Committee is going to consider a bill dealing directly with medical schools' funding, rather than having the issue included in the university funding.

"The medical schools will get about the same amount of money as in the past; but they'll get more attention," he predicts.

A long-standing interest of Geake's is the "Fifth Pathway" bill he's sponsored and introduced in every session since he's been in the legislature.

"Under provisions of this bill, a program would be set up to provide a clinical internship for Michigan residents who have left this country to have their medical education abroad and come back to the United States to finish up," he explained. "I feel these students are American citizens and Michigan residents and they should have the opportunity to complete their medical education here.



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is no laughing matter.**

The first prescription for the first days of acute pain Empirin® $\bar{c}$ Codeine #3

Each tablet contains: aspirin, 325 mg; plus codeine phosphate, 30 mg, (Warning — may be habit-forming). 

For the millions of patients who need the potency of aspirin and codeine for their acute pain.

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EMPIRIN® with Codeine

DESCRIPTION: Each tablet contains aspirin (acetylsalicylic acid) 325 mg plus codeine phosphate in one of the following strengths: No. 2 — 15 mg, No. 3 — 30 mg, and No. 4 — 60 mg (Warning — may be habit-forming) 

CONTRAINDICATIONS: Hypersensitivity to aspirin or codeine

WARNINGS:

Drug dependence: Empirin with Codeine can produce drug dependence of the morphine type and, therefore, has the potential for being abused. Psychic dependence, physical dependence, and tolerance may develop upon repeated administration of this drug and it should be prescribed and administered with the same degree of caution appropriate to the use of other oral, narcotic-containing medications. Like other narcotic-containing medications, the drug is subject to the Federal Controlled Substances Act.

Use in ambulatory patients: Empirin with Codeine may impair the mental and/or physical abilities required for the performance of potentially hazardous tasks such as driving a car or operating machinery. The patient using this drug should be cautioned accordingly.

Interaction with other central nervous system (CNS) depressants: Patients receiving other narcotic analgesics, general anesthetics, phenothiazines, other tranquilizers, sedative-hypnotics, or other CNS depressants (including alcohol) concomitantly with Empirin with Codeine may exhibit an additive CNS depression. When such combined therapy is contemplated, the dose of one or both agents should be reduced.

Use in pregnancy: Safe use in pregnancy has not been established relative to possible adverse effects on fetal development. Therefore, Empirin with Codeine should not be used in pregnant women unless, in the judgment of the physician, the potential benefits outweigh the possible hazards.

PRECAUTIONS:

Head injury and increased intracranial pressure: The respiratory depressant effects of narcotics and their capacity to elevate cerebrospinal fluid pressure may be markedly exaggerated in the presence of head injury, other intracranial lesions or a pre-existing increase in intracranial pressure. Furthermore, narcotics produce adverse reactions which may obscure the clinical course of patients with head injuries.

Acute abdominal conditions: The administration of Empirin with Codeine or other narcotics may obscure the diagnosis or clinical course in patients with acute abdominal conditions.

Allergic: Precautions should be taken in administering salicylates to persons with known allergies; patients with nasal polyps are more likely to be hypersensitive to aspirin.

Special risk patients: Empirin with Codeine should be given with caution to certain patients such as the elderly or debilitated, and those with severe impairment of hepatic or renal function, hypothyroidism, Addison's disease, prostatic hypertrophy or urethral stricture, peptic ulcer, or coagulation disorders.

ADVERSE REACTIONS: The most frequently observed adverse reactions to codeine include light-headedness, dizziness, sedation, nausea and vomiting. These effects seem to be more prominent in ambulatory than in nonambulatory patients and some of these adverse reactions may be alleviated if the patient lies down. Other adverse reactions include euphoria, dysphoria, constipation, and pruritus.

The most frequently observed reactions to aspirin include headache, vertigo, ringing in the ears, mental confusion, drowsiness, sweating, thirst, nausea, and vomiting. Occasional patients experience gastric irritation and bleeding with aspirin. Some patients are unable to take salicylates without developing nausea and vomiting. Hypersensitivity may be manifested by a skin rash or even an anaphylactic reaction. With these exceptions, most of the side effects occur after repeated administration of large doses.

DOSAGE AND ADMINISTRATION: Dosage should be adjusted according to the severity of the pain and the response of the patient. It may occasionally be necessary to exceed the usual dosage recommended below in cases of more severe pain or in those patients who have become tolerant to the analgesic effect of narcotics. Empirin with Codeine is given orally. The usual adult dose for Empirin with Codeine No. 2 and No. 3 is one or two tablets every four hours as required. The usual adult dose for Empirin with Codeine No. 4 is one tablet every four hours as required.

DRUG INTERACTIONS: The CNS depressant effects of Empirin with Codeine may be additive with that of other CNS depressants. See WARNINGS.



Burroughs Wellcome Co.
Research Triangle Park
North Carolina 27709

Long range planning — The conversion of a retreat to an advance

By John R. Ylvisaker, MD, MSMS President



The stimulating, far-reaching discussions were led by Thomas Martin, management consultant of Shawnee Mission, Kansas City, who held the group's discussions together with the aid of a large easel and paper. At left is Ted Vanderveen, MD, Grand Haven.



Medical school representatives included, from left, Andrew D. Hunt, Jr., MD, and Arnold Werner, MD, Michigan State University College of Human Medicine, and Charles C. Vincent, MD, Wayne State University School of Medicine.

For the first time in my memory, MSMS took a different and provocative approach to planning future functions and initiatives. On Sept. 17 and 18 thirty of our members set aside their practice activities to participate in a "retreat" for planning.

The retreat involved an intensive, highly directed discussion of MSMS present and future functions, of its deficiencies and needs, and of its goals and objectives. It occupied a full afternoon, long evening, and

subsequent five hour morning with a hotel stayover for out-of-towners.

The leader was a professional "facilitator," trained and practiced in organized planning, Mr. Thomas Martin. The physician participants represented a broad spectrum of the variety of careers and interests characteristic of MSMS membership — generalist to sub-specialist, academician to clinician, early to late careerist, male and female — organizationally active individuals in-

terspersed with articulate "comers" — all with dynamic or reflective observations which created solid fuel for the planning process.

The sessions were divided into two interlocking steps. The first step was almost a free-wheeling brainstorming of "what is, what isn't, what needs to be, what must be" for MSMS — bottom up and top down thinking, often clashing, softly differing, catalytic or supportive, but analytical and constructive — importantly, not stereotyped.

The second step was an all-too-short exercise in the discipline of translating ideas into specific objectives, programs to accomplish the identified objectives, and precise steps for implementation with built-in accountability. This second step was incomplete and will require the disciplined effort of our Committee on Planning to round out and refine.

I say *disciplined* because it became obvious how difficult, frustrating, and almost exhausting it is to develop realistic objectives with practical steps for accomplishment.

The follow-up will be, first a report from Tom Martin for review by participants. Next, with the assistance of our great MSMS staff, will be the Planning Committee's development of a recommended plan for the Council to review, modify or ratify and, finally, to report to the House of Delegates.

My personal reaction? Delight with the impressive quality of people, ideas and commitment. Frankly, even though I see the dynamism of five to 10 percent of our membership who surface as delegates, component society leaders, or committee participants, I do wonder on occasion about our large "silent majority" — wonder what they're thinking, or if they're thinking, and why they pay the entrance fees but don't play in the game. Seeing and hearing the retreat participants zero in on how they view the importance of the Society, what it stands for, and what it does was a reassuring and rewarding experience.

WHEN ANXIETY AND TENSION MAGNIFY PAIN

IN MUSCULOSKELETAL DISEASE*



A non-narcotic one-two punch against pain, with concurrent relief of anxiety/tension

EQUAGESIC[®] ^C

(meprobamate and ethoheptazine citrate with aspirin) Wyeth

EQUAGESIC—Abbreviated Summary

***INDICATIONS:** Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:

"Possibly" effective for the treatment of pain accompanied by tension and/or anxiety in patients with musculoskeletal disease or tension headache. Final classification of the less-than-effective indications requires further investigation.

The effectiveness of Equagesic in long-term use, i.e. more than four months, has not been assessed by systematic clinical studies. The physician should periodically reassess usefulness of the drug for the individual patient.

CONTRAINDICATIONS: Equagesic should not be given to individuals with a history of sensitivity or severe intolerance to aspirin, meprobamate, or ethoheptazine citrate.

WARNINGS: Careful supervision of dose and amounts prescribed for patients is advised, especially with those patients with known propensity for taking excessive quantities of drugs. Excessive and prolonged use in susceptible persons, e.g., alcoholics, former addicts, and other severe psychoneurotics, has been reported to result in dependence on or habituation to the drug. Where excessive dosage has continued for weeks or months, dosage should be reduced gradually rather than abruptly stopped, since withdrawal of a "crutch" may precipitate withdrawal reaction of greater proportions than that for which the drug was originally prescribed. Abrupt discontinuance of doses in excess of the recommended dose has resulted in some cases in the occurrence of epileptiform seizures.

Special care should be taken to warn patients taking meprobamate that tolerance to alcohol may be lowered with resultant slowing of reaction time and impairment of judgement and coordination.

USAGE IN PREGNANCY AND LACTATION: An increased risk of congenital malformations associated with the use of minor tranquilizers (meprobamate, chlordi-

azepoxide, and diazepam) during the first trimester of pregnancy has been suggested in several studies. Because use of these drugs is rarely a matter of urgency, their use during this period should almost always be avoided. The possibility that a woman of child-bearing potential may be pregnant at the time of institution of therapy should be considered. Patients should be advised that if they become pregnant during therapy or intend to become pregnant they should communicate with their physicians about the desirability of discontinuing the drug.

Meprobamate passes the placental barrier. It is present both in umbilical-cord blood at or near maternal plasma levels and in breast milk of lactating mothers at concentrations two to four times that of maternal plasma. When use of meprobamate is contemplated in breast-feeding patients, the drug's higher concentrations in breast milk as compared to maternal plasma levels should be considered.

Preparations containing aspirin should be kept out of the reach of children. Equagesic is not recommended for patients 12 years of age and under.

PRECAUTIONS: Should drowsiness, ataxia, or visual disturbance occur, the dose should be reduced. If symptoms continue, patients should not operate a motor vehicle or any dangerous machinery.

Suicidal attempts with meprobamate have resulted in coma, shock, vasomotor and respiratory collapse, and anuria. Very few suicidal attempts were fatal, although some patients ingested very large amounts of the drug (20 to 40 gm). These doses are much greater than recommended. The drug should be given cautiously, and in small amounts, to patients who have suicidal tendencies. In cases where excessive doses have been taken, sleep ensues rapidly and blood pressure, pulse, and respiratory rates are reduced to basal levels. Hyperventilation has been reported occasionally. Any drug remaining in the stomach should be removed and symptomatic treatment given. Should respiration become very shallow and slow, CNS stimulants, e.g., caffeine, Metrazol, or am-

phetamine, may be cautiously administered. If severe hypotension develops, pressor amines should be used parenterally to restore blood pressure to normal levels.

ADVERSE REACTIONS: A small percentage of patients may experience nausea with or without vomiting and epigastric distress. Dizziness occurs rarely when meprobamate and ethoheptazine citrate with aspirin is administered in recommended dosage. The meprobamate may cause drowsiness but, as a rule, this disappears as therapy is continued. Should drowsiness persist and be associated with ataxia, this symptom can usually be controlled by decreasing the dose, but occasionally it may be desirable to administer central stimulants such as amphetamine or mephentermine sulfate concomitantly to control drowsiness.

A clearly related side effect to the administration of meprobamate is the rare occurrence of allergic or idiosyncratic reactions. This response develops, as a rule, in patients who have had only 1-4 doses of meprobamate and have not had a previous contact with the drug. Previous history of allergy may or may not be related to the incidence of reactions.

Mild reactions are characterized by an itchy urticarial or erythematous, maculopapular rash which may be generalized or confined to the groin. Acute nonthrombocytopenic purpura with cutaneous petechiae, ecchymoses, peripheral edema, and fever have also been reported.

More severe cases, observed only very rarely, may also have other allergic responses, including fever, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anaphylaxis, stomatitis and proctitis (1 case), and hyperthermia. Treatment should be symptomatic such as administration of epinephrine, antihistamine, and possibly hydrocortisone. Meprobamate should be stopped, and reinstitution of therapy should not be attempted.

Rare cases have been reported where patients receiving meprobamate suffered from aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis, and hemolytic anemia. In nearly every instance reported, other toxic agents known to have caused these conditions have been associated with meprobamate. A few cases of leukopenia during

continuous administration of meprobamate are reported, most of these returned to normal without discontinuation of the drug.

Impairment of accommodation and visual acuity has been reported rarely.

OVERDOSE: Two instances of accidental or intentional significant overdose with ethoheptazine citrate combined with aspirin have been reported. These were accompanied by symptoms of CNS depression, including drowsiness and light-headedness, with uneventful recovery. However, on the basis of pharmacological data, it may be anticipated that CNS stimulation could occur. Other anticipated symptoms would include nausea and vomiting. Appropriate therapy of signs and symptoms as they appear is the only recommendation possible at this time. Overdosage with ethoheptazine combined with aspirin would probably produce the usual symptoms and signs of salicylate intoxication. Observation and treatment should include induced vomiting or gastric lavage, specific parenteral electrolyte therapy for ketoacidosis and dehydration, watching for evidence of hemorrhagic manifestations due to hypoprothrombinemia which, if it occurs, usually requires whole-blood transfusions.

DESCRIPTION: Each Equagesic tablet contains 150 mg meprobamate, 75 mg ethoheptazine citrate and 250 mg aspirin.

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*This drug has been evaluated as possibly effective for this indication.

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FOR MODERATE PAIN

A therapeutic dose
of acetaminophen
in *one* tablet

A therapeutic dose
of two complementary
analgesics

The convenience and
economy of a
dosage schedule of
one tablet, every four
hours as needed



WHY NOT WYGESIC[®] [©]

(65 mg propoxyphene HCl and 650 mg acetaminophen) Wyeth

WYGESIC—Abbreviated Summary

INDICATION: For the relief of mild-to-moderate pain.

CONTRAINDICATION: Hypersensitivity to propoxyphene or to acetaminophen.

WARNINGS: CNS ADDITIVE EFFECTS AND OVERDOSAGE. Propoxyphene in combination with alcohol, tranquilizers, sedative-hypnotics, or other CNS depressants has an additive depressant effect. Patients taking this drug should be advised of the additive effect and warned not to exceed the dosage recommended. Toxic effects and fatalities have occurred following overdoses of propoxyphene alone or in combination with other CNS depressants. Most of these patients had histories of emotional disturbances or suicidal ideation or attempts, as well as misuse of tranquilizers, alcohol, or other CNS-active drugs. Caution should be exercised in prescribing large amounts of propoxyphene for such patients (See Management of Overdosage).

DRUG DEPENDENCE: Propoxyphene can produce drug dependence characterized by psychic dependence and less frequently, physical dependence and tolerance. It will only partially suppress the withdrawal syndrome in individuals physically dependent on morphine or other narcotics. The abuse liability of propoxyphene is qualitatively similar to codeine's although quantitatively less, and propoxyphene should be prescribed with the same degree of caution appropriate to the use of codeine.

USAGE IN AMBULATORY PATIENTS: Propoxyphene may impair the mental and/or physical abilities required for potentially hazardous tasks, e.g. driving a car or operating machinery. Patients should be cautioned accordingly.

USAGE IN PREGNANCY: Safe use in pregnancy has not been established relative to possible adverse effects on fetal development. **INSTANCES OF WITHDRAWAL SYMPTOMS IN THE NEONATE HAVE BEEN REPORTED FOLLOWING USAGE DURING PREGNANCY.** Therefore, propoxyphene should not be used in pregnant women unless, in the

judgement of the physician, the potential benefits outweigh the possible hazards.

USAGE IN CHILDREN: Propoxyphene is not recommended for children because documented clinical experience has been insufficient to establish safety and a suitable dosage regimen in the pediatric group.

PRECAUTIONS: Confusion, anxiety, and tremors have been reported in a few patients receiving propoxyphene concomitantly with orphenadrine. The CNS depressant effect of propoxyphene may be additive with other CNS depressants, including alcohol.

ADVERSE REACTIONS: The most frequent adverse reactions are dizziness, sedation, nausea, and vomiting. These seem more prominent in ambulatory than in nonambulatory patients, some of these reactions may be alleviated if the patient lies down.

Other adverse reactions include constipation, abdominal pain, skin rashes, light-headedness, headache, weakness, euphoria, dysphoria, and minor visual disturbances. The chronic ingestion of propoxyphene in doses over 800 mg per day has caused toxic psychoses and convulsions. Cases of liver dysfunction have been reported.

DRUG INTERACTIONS: Propoxyphene in combination with alcohol, tranquilizers, sedative-hypnotics, and other CNS depressants has an additive depressant effect. Patients taking this drug should be advised of the additive effect and warned not to exceed the dosage recommended. (See Warnings) Confusion, anxiety, and tremors have been reported in a few patients receiving propoxyphene concomitantly with orphenadrine.

MANAGEMENT OF OVERDOSAGE: SYMPTOMS The manifestations of serious overdosage with propoxyphene are similar to those of narcotic overdosage and include respiratory depression (a decrease in respiratory rate and/or tidal volume, Cheyne-Stokes respiration, cyanosis), extreme somnolence progressing to stupor or coma, pupillary constriction, and circulatory collapse. In addition to these characteristics, which are reversed by narcotic antago-

nists such as naloxone, there may be other effects. Overdoses of propoxyphene can cause delay of cardiac conduction as well as focal or generalized convulsions, a prominent feature in most cases of severe poisoning. Cardiac arrhythmias and pulmonary edema have occasionally been reported, and apnea, cardiac arrest, and death have occurred.

Symptoms of massive overdosage with acetaminophen may include nausea, vomiting, anorexia, and abdominal pain, beginning shortly after ingestion and lasting for 12 to 24 hours. However, early recognition may be difficult since early symptoms may be mild and nonspecific. Evidence of liver damage is usually delayed. After the initial symptoms, the patient may feel less ill; however, laboratory determinations are likely to show a rapid rise in liver enzymes and bilirubin. In case of serious hepatotoxicity, jaundice, coagulation defects, hypoglycemia, encephalopathy, coma, and death may follow. Renal failure due to tubular necrosis, and myocardialopathy, have also been reported.

Ingestion of 10 grams or more of acetaminophen may produce hepatotoxicity. A 13-gram dose has reportedly been fatal.

TREATMENT: Primary attention should be given to the reestablishment of adequate respiratory exchange through provision of a patent airway and institution of assisted or controlled ventilation. The narcotic antagonists, naloxone, nalorphine, and levallorphan, are specific antidotes against the respiratory depression produced by propoxyphene. An appropriate dose of one of these antagonists should be administered, preferably IV, simultaneously with efforts at respiratory resuscitation and the antagonist should be repeated as necessary until the patient's condition remains satisfactory. In addition to a narcotic antagonist, the patient may require careful titration with an anticonvulsant to control seizures. Analeptic drugs (e.g. caffeine or amphetamine) should not be used because of their tendency to precipitate convulsions.

Oxygen, IV fluids, vasopressors and other supportive measures should be used as indicated. Gastric lavage may be helpful. Activated charcoal can absorb a significant amount of ingested propoxyphene. Dialysis is of little value in poisoning by propoxyphene alone. Acetaminophen is rapidly absorbed, and efforts to remove the drug from the body should not be delayed. Copious gastric lavage and/or induction of emesis may be indicated. Activated charcoal is probably ineffective unless administered almost immediately after acetaminophen ingestion. Neither forced diuresis nor hemodialysis appears to be effective in removing acetaminophen. Since acetaminophen in overdose may have an antidiuretic effect and may produce renal damage, administration of fluids should be carefully monitored to avoid overload. It has been reported that mercaptamine (cysteine) or other thiol compounds may protect against liver damage if given soon after overdosage (8-10 hours). N-acetylcysteine is under investigation as a less toxic alternative to mercaptamine, which may cause anorexia, nausea, vomiting, and drowsiness. Appropriate literature should be consulted for further information (JAMA 237:2406-2407, 1977). Clinical and laboratory evidence of hepatotoxicity may be delayed up to one week. Acetaminophen plasma levels and half-life may be useful in assessing the likelihood of hepatotoxicity. Serial hepatic enzyme determinations are also recommended.

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Michigan's Indochinese refugees come from variety of cultural backgrounds

Over 7,000 Indochinese refugees are new residents of Michigan at this writing!

Many of them are patients of Michigan physicians.

The following articles are part of a continuing series begun with the July issue of *Michigan Medicine*. The series is dedicated to helping Michigan physicians better know and understand the physical and cultural conditions of these new Michiganders.

In this issue, we describe the cultural backgrounds of the Laotians, the Hmong clansmen of Laos, the Cambodians, and the ethnic Chinese in Vietnam, many of whom became the "boat people." (The Vietnamese were profiled in the September issue.)

Articles here also provide immunization and medical screening needs of the refugees, and the public health significance of their medical condition on arrival in the United States.

Chinese in Vietnam

The first Chinese people in Vietnam came as mandarins, or rulers almost 2,000 years ago. Since that time, Chinese have fled to Vietnam to escape political strife, and to take advantage of trade with western countries. With their business skills and acumen, they began to gain control of Vietnamese economics. Resentment toward them also began to grow.

Concentrated in urban areas, the Ethnic Chinese population in South Vietnam was estimated at 1,200,000 in 1970, representing about 5.5 percent of the total population.

In the 1970's hostility towards the Ethnic Chinese began to increase. In 1977, the Vietnamese government began a policy of "purifying the border areas" and forced large numbers of Chinese residents over the border into China. In the South, Vietnamese officials began policies of harassment and discrimination against the overseas Chinese which were designed to



The Vietnamese, Chinese, Laotian and Hmong refugees moved through food lines in refugee camps. Transitions from their former ways of life, through the refugee camps and now, to American customs, are monumental.

drive them out of the country.

By late 1978, overseas Chinese were leaving Vietnam in large numbers, both by sea and across the border to China.

The reasons for the wholesale expulsion of their Ethnic Chinese population are complicated. Vietnam claims the process is part of their policy of socialist reconstruction and that there is no room for the capitalistic Ethnic Chinese in their new society. The Peoples Republic of China accuses the Vietnamese government of using the overseas Chinese as part of a general anti-China program. The actual impetus for the expulsion remains a confusing issue.

The Lao

Laos lies in the heart of Indochina. It is a mountainous country, bordered by Vietnam on the east, Cambodia on the south, Thailand on the west and Burma and China on the

north. The country has two seasons; southwest winds produce a six-month rainy period, and monsoonal land winds from the northeast produce a dry period for the other half of the year.

Traditionally settlement in Laos has been along the Mekong River lowlands. The Mekong has always served as the center of the country's economic life. The Mekong flows through (or borders on) Laos for more than 1,000 miles. Its flood plains provide major wet-rice lands, and its waters provide the main protein element of the Lao diet, fish.

The people residing along the river are called lowland Lao, or simply, Lao. The elevations from 3,000 to 6,000 feet are settled by the highlanders of Laos — the Hmong.

The Lao represented the largest ethnic group in Laos. The Lao are a subgroup of the Tai people, having originated in southern China. Their



language is part of the Lao Tai family. It is a tonal language in which local dialects are distinguished by difference in the number of tones and the way they are applied.

The Lao family is the principal social unit, and the Laotian culture is very similar to the Vietnamese in regards to the family.

For the Lao there are two basic values, kingchai and piap: Kingchai is basically respecting others while keeping a low personal profile. A practical demonstration of kingchai is the different forms of speech which are used to respectfully address people from different backgrounds. Kingchai promotes unaggressive, non-assertive behavior.

While kingchai is essentially a behavior value, piap is an existential value. Piap is the integration of one's soul with familial pride and integrity. A person's piap is closely related to his or her family background; the better the background of the family, the more piap a person has.

This ties in with an important cultural trait of the Lao. People generally act the way they are expected to act, rather than the way they want to act or feel like acting. Thus, a person from a good family background is expected to live up to high behavioral expectations, and probably will do so.

Religion in Laos also is similar to Vietnamese beliefs, minus the influence of Catholicism.

While a Lao practices Buddhism to help achieve holiness and good-

ness in the lives to come, a Lao Buddhist may also engage in phi (spirit) worship to help him deal with troubles of the here and now.

The educational system in Laos was not well developed. In fact, a 1968 study estimated only 25 percent of the population was literate. School attendance was compulsory for children between the ages of 6 and 14, who lived within one kilometer of a school. However this was not strictly enforced. Also, complete elementary and secondary education was not available until the late 1960's, and even then was available only in key cities. Because of the lack of readily accessible public education, the educated elite became dependent on French secondary schools and colleges.

The Hmong

The Hmong are Laotian highlanders who prefer to live in the mountains where the climate is cool. The Hmong (which means "free man") were indigenous to China, and spread southward during the late 18th and early 19th centuries.

In Laos the ideal occupation for the Hmong was farming. Men and women shared equally in the field work. Growing mainly rice and corn, they practiced a slash and burn type of agriculture; when fields became infertile, new fields were sought. The Hmong were also celebrated livestock breeders, and would move their herds when they moved to a new settlement.

As with other Indochinese cultural groups, the family is the key to Hmong social structure. One of the most important social virtues is putting the needs and desires of the family or group before the individual's self-interest.

The basic Hmong household consists of the nuclear family and married sons and their families. The Hmong family is usually large, partly because the Hmong place great importance on insuring the family line of succession.

While the family has traditionally been at the center of Hmong social organization, the strong tradition of self-reliance and independence can only flourish when a number of Hmong families have the opportunity to cooperate. For that reason, the patrilineal clan

system serves as the primary focus for the culture by tying together social, political, economic and religious aspects of behavior.

Seniority is the major criterion for ordering relations within the clan. Elder clan members are respected and esteemed. Clan members are very conscious of their status in the clan hierarchy, and use appropriate, respectful speech and behavior in dealing with other clan members.

Linguistically, the Hmong belong to the Sino-Tibetan family. The Hmong language is monosyllabic with seven tones. The Hmong language has only recently been developed into a written form. Christian missionaries introduced the roman alphabet, and the Pathet-Lao developed a system of writing using Lao characters.

Many people feel that of all of the Southeast Asian cultural groups, the Hmong took the greatest risks and suffered the largest number of casualties during the war while serving U.S. interests. In fact, virtually all of the tribal Hmong were involved in the war, acting as a major force in the northeast region of Laos. So intense was their involvement in the 15 years of war that roughly 30,000 Hmong were killed in action.

The Hmong refugees in the U.S. are laboring to preserve their cultural identity. At the same time they are working hard to incorporate themselves in the fabric of American culture. Accustomed to the mountainous, rural life, the Hmong must make massive adjustments to American urban life.

Cambodia

Cambodia, now shrunk to a tiny country in Southeast Asia, was once a huge empire. The country is a rich agricultural land and underpopulated, thus attracting foreigners.

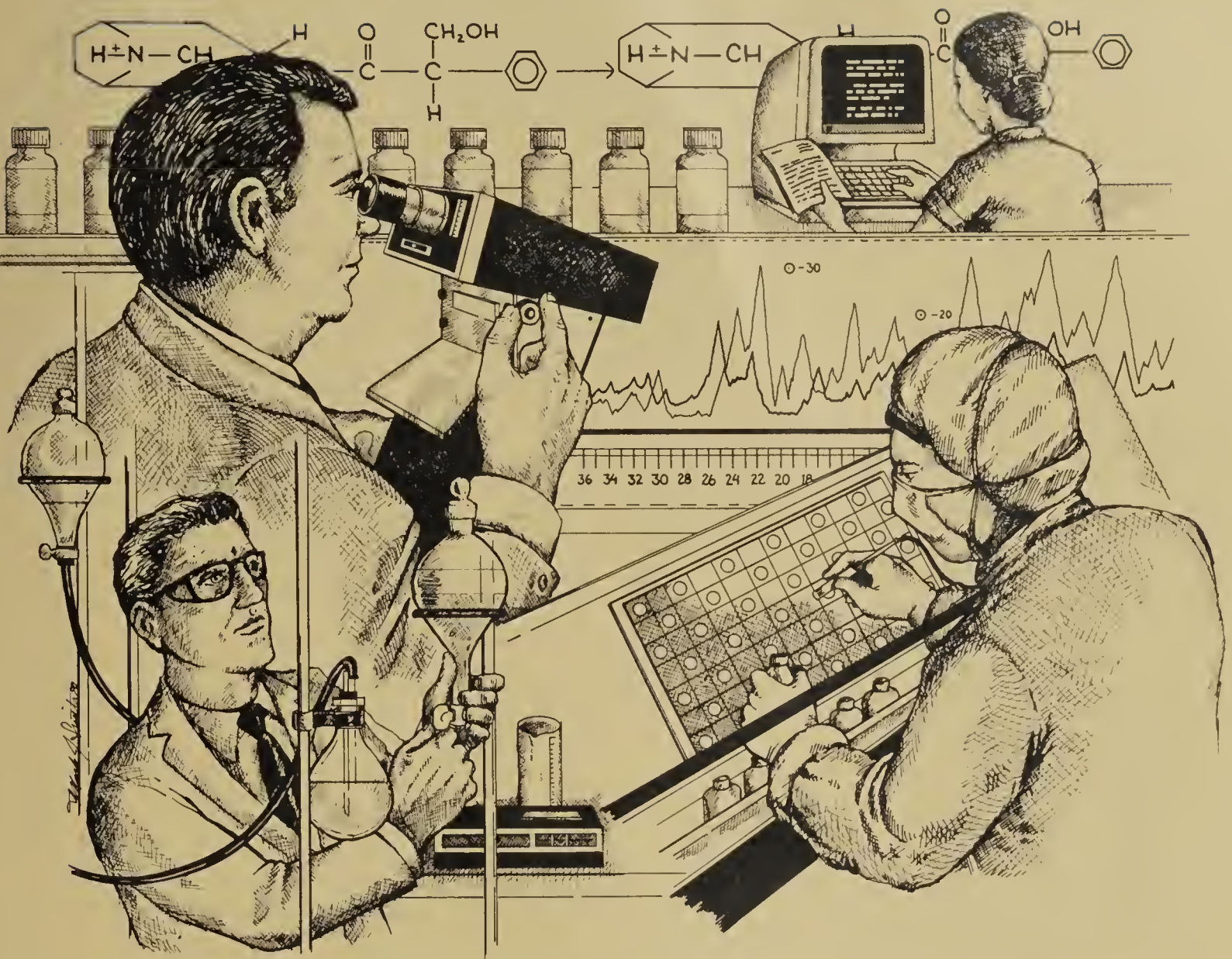
The Cambodians are accustomed to enjoying a good and easy life, a life molded by the hot and humid climate and the strong influence of the Buddhist religion.

The country is predominantly agricultural and 90 percent of the population gains its living from agriculture.

The main products which are exported include rice, corn, rubber and textiles. Industry is less impor-

continued on page 578

Leadership.



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Four carefully executed "mercy missions" to refugee camps in Cambodia are among the results of Michigan's own statewide refugee relief drive.

The Michigan Refugee Relief Fund, established a year ago by Governor Milliken following his personal visit to the refugee camps, is seeking Michigan physicians' donations. Michigan doctors' donations to date helped fund those four dramatic mercy missions in late August and early September.

Here are some figures to help comprehend the magnitude of gifts:

\$1,500 will buy 5 tons of rice

\$1,000 will buy 20 deepwell pumps for village water

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\$300 will buy A and D vitamins for 1,000 children for one month

\$250 will buy fish and rice for 10 families of five for one month

\$210 will buy 1,000 pounds of skim milk powder

\$170 will buy 100,000 multi-vitamins with iron

\$60 will buy fish and rice for 10 men for one month

Any contribution will buy the gift of life for suffering humanity in those Southeast Asian refugee camps.

Physicians may send their contributions to the Michigan Refugee Relief Fund, Box 55-316 A, Detroit, MI 48255.

CAMBODIA/continued

tant, but during the last years before the war, special efforts were made to develop this branch of the economy. Cambodia also is well known for silver handicrafts and precious stones (zircons, sapphires, rubies).

For the average Cambodian, the essential doctrine by which conduct can be gauged is merit: A person's character and all that happens to him or her are weighed on the merit-demerit scale. Good deeds and bad deeds are irrevocable and become sculptured into character. The simple axiom of behavior is that a person reaps what he sows, whether he be a king, a commoner or, through unfortunate reincarnation, a dog. Cambodians do not doubt that he who does good receives good and he who does evil receives evil.

It is generally admitted that most Cambodians believe in superstitions and that the supernatural traditions have deep historical roots in Cambodia. The supernatural traditions combine animism, sorcery, naturalism and magical rites.

In general Cambodians prefer to have their social relationships clearly defined so that each person involved

has a distinct status and a prescribed role to play. There is security in thus knowing precisely where an individual stands, what is expected of him and others, what he and others can and cannot do.

The rules of etiquette between people of different status and rank are carefully spelled out, and every status and rank has its appropriate and circumscribed roles for every situation. Once the situation has been recognized and the appropriate formal courtesies exchanged, individuals are willing to shift to a more informal kind of interchange, but the basic definition of the situation and the limits of behavior must still be adhered to.

Cambodians feel that the individual should be continually attuned to the Buddhist code of personal conduct. Nonviolence is another important precept, and crimes of violence such as assault, murder and rape are extremely rare. In general, temperance, diligence, thrift and self-discipline are stressed.

The ideal household consists of a married couple and their unmarried children. This pattern is general in the urban districts. But in rural areas households include most of the time,

married children and their families, because of economic factors, because there is more space available, because usually the houses are larger, or because they just want to live with closer ties.

The Cambodian family is usually a large family, and the average is a family of four or five children. The Cambodian does not want unlimited offspring, although accepts with genuine pleasure those that come. Because polygamy is legal, one wouldn't be surprised to see a family of 15 or more children.

The family usually lives in a closely knit unit. It is usual and normal to see the grandparents sharing the same house with their married children or married grandchildren. The grandparents usually help with the daily miscellaneous work in the household, such as taking care of the house, or taking care of the infants while their parents go to work. As in other Asian societies, the Cambodians don't send the elderly to a nursing home. Respect for one's elder is expected of everyone. Buddhist teaching stresses deference to the wishes of an elder and is still the dominant influence on a young Cambodian's behavior.

The Cambodian woman occupies a key position in the household, and in many ways the prosperity, well-being and development of the family as a unit revolve around her. Her ethical influence over the younger minds is very important. As a carrier of the basic social and moral values of Cambodian culture, she is highly regarded by the men in her own family and by Cambodian society at large.

In the round of family activities, the wife stands on an equal footing with her husband — in some matters she surpasses him in initiative. Generally it is the wife who is the treasurer, controlling the purse strings and budgeting the family assets.

This article is excerpted, with permission from reports prepared by the Lutheran Council in the USA's Department of Immigration and Refugee Services.

more on page 580

DESCRIPTION: Methyltestosterone is 17 β -Hydroxy-17-Methylandroster-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunuchism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-puberal cryptorchidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric,

avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE**

REACTIONS: Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. In the male: Eunuchoidism and eunuchism, 10 to 40 mg. Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg. Postpuberal cryptorchism, 30 mg. **REFERENCE:** R. B. Greenblatt, M.D.; R. Witherington, M.D.; I. B. Sipahioğlu, M.D. Hormones for Improved Sexuality in the Male and the Female Climacteric. *Drug Therapy*, Sept. 1976. **SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only

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Refugees' public health aspects

By Maurice S. Reizen, MD, Lansing

Since the Indochinese refugees first began arriving in Michigan five years ago, the number entering monthly has increased. Currently there are approximately 280 refugees arriving each month, with the total number in the state now estimated at 7,000.

Screening in the overseas camps for communicable diseases is minimal (VDRL, chest x-ray for those over 15 years of age, and a visual check for leprosy), and has resulted in some refugees entering our state with undetected disease.

We are notified, of course, of any conditions which are detected in order that the local health department can be alerted for proper followup.

Tuberculosis

From a public health point of view, tuberculosis is probably the most important disease problem among the Indochinese refugees. The prevalence of disease and occurrence of drug resistance in the refugees' countries of origin are different from those in the United States and require some modification of the standard approaches to screening, diagnosis, and treatment.

Approximately 50 percent of the refugees are tuberculin positive. While the proportion of these reactors who have had BCG vaccination is not known, the current recommendation is to consider the patient a true reactor and treat prophylactically, as indicated, in accordance with the American Thoracic Society/Center for Disease Control guidelines. These reactors present a pool of potential new cases which can be reduced through the appropriate use of INH prophylaxis.

During the five year period 1975-1979, there were an average of 20 cases of TB in refugees, requiring multi-drug therapy, reported each year to the Michigan Department of Public Health. These cases repre-

sented about two percent of our caseload during that period.

The situation this year is different, as the number of refugees arriving continues to increase. Through June of this year there were 64 cases reported in refugees, representing 11 percent of our caseload for the year. Two of these cases occurred in children under 15 years of age (the group not screened for TB overseas).

The majority of the refugee TB cases are being treated by local health departments and, therefore, the private physician may not see any cases in his or her practice.

But as these people become integrated into our culture, more of their care necessarily will be provided by private physicians and the opportunity for physicians to see a case of tuberculosis will increase.

Due to the high level of drug-resistant organisms, the Center for Disease Control is recommending that all bacteriologically-proven cases be treated with three drugs (isoniazid, rifampin, and ethambutol). Children too young to be assessed for alterations of visual acuity should receive isoniazid, rifampin and streptomycin.

Hepatitis B

Various studies of incoming refugee groups have shown that 12-14 percent may be asymptomatic carriers of hepatitis B surface antigen (HBsAg). No treatment is necessary, but a risk of transmission exists for health professionals (dental practitioners, gynecologists-obstetricians and surgeons) having intimate contact with infected individuals.

Ideally, all refugees should be screened for hepatitis B surface antigen and the results entered in their medical records. Even with the documented 12-14 percent carrier rate, the number of hepatitis cases being reported to the Michigan Department of Public Health has not increased over prior years.

Intestinal Parasites

In general, these organisms pre-

sent more of a threat to the refugees' personal health than to the public health. Intestinal helminths do not pose a significant public health hazard since adequate sewage systems in this country interrupt transmission. The protozoans could be transmitted via the fecal/oral route through food or water if the infected individual did not practice adequate personal hygiene. We have received no reports of this happening to any large extent. Heightened surveillance would be required for refugee food handlers.

A large percentage (up to 60 percent) of refugees are infected with intestinal parasites and testing for them is indicated as part of a complete examination. The most common species found are hookworms, giardia, trichuris and ascaris, with multiple infections common.

Malaria

Although malaria is endemic in Southeast Asia, it is not expected to present a problem in Michigan. Transmission in our state is very unlikely due to the life-cycle requirements of the organism.

Immunizations

Refugees who have had immunization series initiated overseas will possess an immunization record form; their series should be completed in accordance with recommended immunization schedules.

A very high percentage of adult refugees will undoubtedly have natural antibodies to polio virus and measles. It is recommended, however, that their tetanus and diphtheria immune status be brought up to date by administration of Td vaccine.

More detailed information on refugee health problems was printed in the Morbidity and Mortality Weekly Report from the Center for Disease Control (Vol. 28, #33 & 39; Vol. 29, #1 & 4) which is available from the Division of Epidemiology, Michigan Department of Public Health.

Doctor Reizen is director of the Michigan Department of Public Health.

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Area VII PSRO has unique tests to assure high quality of care

By Robert Medlar, MD, Jackson

Area VII PSRO, in operation since 1977, has used a blend of "tried and true" methods and innovative ideas to assure the delivery of high quality medical care in the 15 hospitals in our area (Jackson, Hillsdale, Lenawee, Monroe, and Washtenaw counties).

For instance, we have tried to strengthen and build on the medical audit expertise already in our hospitals, and to emphasize the need for such studies to be problem-oriented. By having a physician committee review and comment on each audit we feel these studies have become much more effective tools for delineating and correcting problem areas in many of our hospitals.

New approach

In concurrent review of the medical necessity of hospitalization, we have, on the other hand, adopted a new approach based on the patients' problems according to body system instead of upon admitting diagnosis. Our Criteria, Standards, and Norms Committee piloted this approach in two of our hospitals during 1978. This test convinced us that this way of looking at severity of illness (SI) and intensity of services (IS) criteria in order to screen cases for physician advisor review did a better job of assuring physicians saw necessary cases.

If, for example, a patient was admitted with abdominal pain, the review coordinator would consult our gastrointestinal system criteria category to see whether either severity of illness or intensity of services criteria were met.

To meet severity of illness criteria, the patient would have to have abdominal pain with proven ulcer (by X-ray) not responsive to one week of outpatient treatment; or, perhaps, abdominal pain with 1) tenderness, 2) draining, 3) rebound, 4) rigidity, or 5) decreased bowel sounds.

In addition to talking about the illness, we also look at intensity of service at admission and during continued stay. Examples of these criteria are whether the patient is scheduled for 1) invasive diagnostic process or 2) intravenous fluids and hyperalimentation.

After revision, these SI/IS criteria were adopted in our hospitals in June and July of 1979. A number of revisions have been made subsequently.

Study Section

Since 1979, we have been working with Joseph Restuccia, DrPH, (assistant professor, Boston University, formerly of the University of Michigan School of Public Health) to formally assess the reliability and validity of the SI/IS Criteria.

Summary results from an analysis of over 2,000 decisions by review coordinators (nurses and health record analysts) and physicians at three sample hospitals include the following:

1. In evaluating cases for "appropriateness," the reviewers considered timeliness and availability of services delivered to patients as well as whether the patient required hospitalization. Thus, a patient could be considered inappropriately hospitalized as a result of factors external to his/her physician or hospital. For example, a patient awaiting placement in a skilled or intermediate nursing facility due to unavailability of a bed would be considered "inap-

propriately" hospitalized. In addition, decisions were based solely on the available documentation within the patient's medical chart.

Of the 96 cases reviewed, over 90 percent of the admissions were found to be medically necessary by the PSRO physician judgments. Review of the medical necessity of continued stay hospitalization indicated 70 percent were "appropriately" hospitalized at the acute care level.

2. The reliability or consistency of decision-making between reviewers was higher for admission review than for continued stay. The same decisions were reached 90 percent of the time when any two reviewers applied the criteria to a given admission. This rate was identical to the agreement rate of the two reviewing physicians who also agreed on 90 percent of their decisions using professional judgment.

The agreement rate between reviewers applying criteria to continued stay days was 70 percent. Continued stay reviews were found to be more complex, with a great number of variables to be evaluated during the decision-making. This was indicated by the physician agreement rate of only 67 percent for continued stay reviews compared to 89 percent for admission review.

3. In measuring validity, the criteria decisions were compared to the "correct" decision which was determined by agreement between the two physician reviewers, or in cases of disagreement, the majority of the PSRO Criteria Committee. For admission review, the criteria predicted the physician decision 92 percent of the time, which is rather impressive. For continued stay reviews the rate was 70 percent, but given the fact that the two physician reviewers disagreed 33 percent of the time, this rate is good.

While the study rates are generally quite favorable for the use of the SI/IS Criteria for screening purposes, these findings do indicate the complexities and difficulties of making appropriateness decisions and underlie the importance of having these decisions made under the direction of a physician group such as PSRO.

Doctor Medlar is Area VII PSRO president. He is a surgeon.

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Final classification of the less-than-effective indications requires further investigation.

Contraindications: Glaucoma, prostatic hypertrophy, benign bladder neck obstruction, hypersensitivity to chlordiazepoxide HCl and/or clidinium Bromide

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants, and against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Physical and psychological dependence rarely reported on recommended doses, but use caution in administering Librium[®] (chlordiazepoxide HCl/Roche) to known addic-

tion-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions) reported following discontinuation of the drug.

Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy. Advise patients to discuss therapy if they intend to or do become pregnant.

As with all anticholinergics, inhibition of lactation may occur.

Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules/day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such as MAO inhibitors, phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions reported in psychiatric patients. Employ usual precautions in treating anxiety states with evidence of impending depression, suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation reported very rarely in patients receiving the drug

and oral anticoagulants, causal relationship not established.

Adverse Reactions: No side effects or manifestations not seen with either compound alone reported with Librax. When chlordiazepoxide HCl is used alone, drowsiness, ataxia, confusion may occur, especially in elderly and debilitated, avoidable in most cases by proper dosage adjustment, but also occasionally observed at lower dosage ranges. Syncope reported in a few instances. Also encountered: isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent, generally controlled with dosage reduction; changes in EEG patterns may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice, hepatic dysfunction reported occasionally with chlordiazepoxide HCl, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax typical of anticholinergic agents, i.e., dryness of mouth, blurring of vision, urinary hesitancy, constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.

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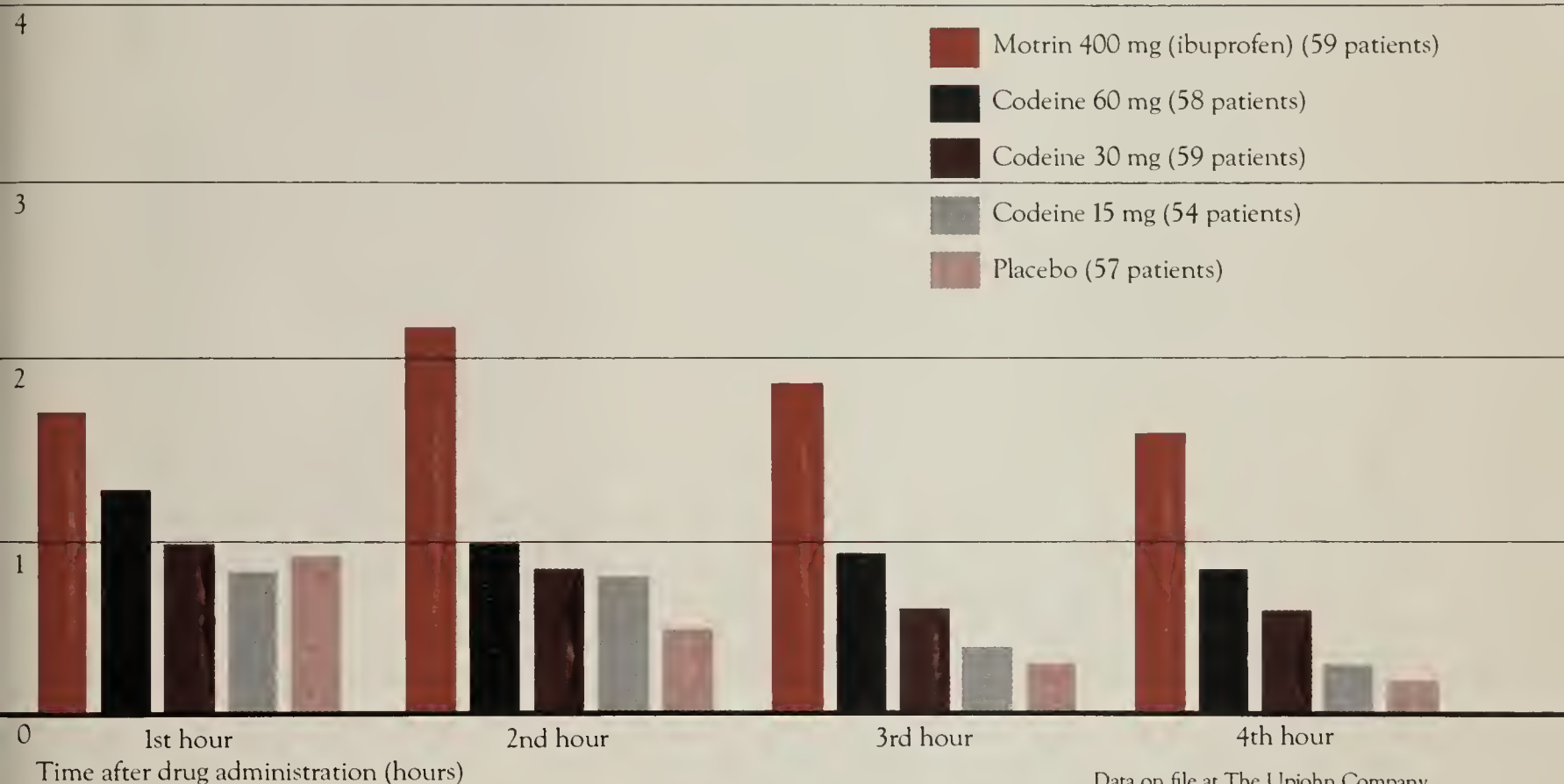
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mild to moderate pain

Motrin[®] Tablets (ibuprofen, Upjohn)

Indications and Usage: Relief of mild to moderate pain.

Treatment of signs and symptoms of rheumatoid arthritis and osteoarthritis during acute flares and in long-term management. Safety and efficacy have not been established in Functional Class IV rheumatoid arthritis.

Contraindications: Individuals hypersensitive to it, or with the syndrome of nasal polyps, angioedema and bronchospastic reactivity to aspirin or other nonsteroidal anti-inflammatory agents (see WARNINGS).

Warnings: Anaphylactoid reactions have occurred in patients with aspirin hypersensitivity (see CONTRAINDICATIONS).

Peptic ulceration and gastrointestinal bleeding, sometimes severe, have been reported. Ulceration, perforation, and bleeding may end fatally. An association has not been established. Motrin should be given under close supervision to patients with a history of upper gastrointestinal tract disease, only after consulting ADVERSE REACTIONS.

In patients with active peptic ulcer and active rheumatoid arthritis, nonulcerogenic drugs, such as gold, should be tried. If Motrin must be given, the patient should be under close supervision for signs of ulcer perforation or gastrointestinal bleeding.

Precautions: Blurred and/or diminished vision, scotomata, and/or changes in color vision have been reported. If these develop, discontinue Motrin and the patient should have an ophthalmologic examination, including central visual fields.

Fluid retention and edema have been associated with Motrin; use with caution in patients with a history of cardiac decompensation.

Motrin can inhibit platelet aggregation and prolong bleeding time. Use with caution in persons with intrinsic coagulation defects and those on anticoagulant therapy.

Patients should report signs or symptoms of gastrointestinal ulceration or bleeding, blurred vision or other eye symptoms, skin rash, weight gain, or edema.

To avoid exacerbation of disease or adrenal insufficiency, patients on prolonged corticosteroid therapy should have therapy tapered slowly when Motrin is added.

Drug interactions. Aspirin used concomitantly may decrease Motrin blood levels. Coumarin: Bleeding has been reported in patients taking Motrin and coumarin.

Pregnancy and nursing mothers: Motrin should not be taken during pregnancy or by nursing mothers.

Adverse Reactions

Incidence greater than 1%

Gastrointestinal: The most frequent type of adverse reaction occurring with Motrin is gastrointestinal (4% to 16%). This includes nausea,* epigastric pain,* heartburn,* diarrhea, abdominal distress, nausea and vomiting, indigestion, constipation, abdominal cramps or pain, fullness of the GI tract (bloating and flatulence). **Central Nervous System:** Dizziness,* headache, nervousness. **Dermatologic:** Rash* (including maculopapular type), pruritus. **Special Senses:** Tinnitus. **Metabolic:** Decreased appetite, edema, fluid retention. Fluid retention generally responds promptly to drug discontinuation (see PRECAUTIONS).

*Incidence 3% to 9%.

Incidence less than 1 in 100

Gastrointestinal: Upper GI ulcer with bleeding and/or perforation, hemorrhage, melena.

Central Nervous System: Depression, insomnia. **Dermatologic:** Vesiculobullous eruptions, urticaria, erythema multiforme. **Cardiovascular:** Congestive heart failure in patients with marginal cardiac function, elevated blood pressure. **Special Senses:** Amblyopia (see PRECAUTIONS). **Hematologic:** Leukopenia, decreased hemoglobin and hematocrit.

Causal relationship unknown

Gastrointestinal: Hepatitis, jaundice, abnormal liver function. **Central Nervous System:** Paresthesias, hallucinations, dream abnormalities. **Dermatologic:** Alopecia, Stevens-Johnson syndrome. **Special Senses:** Conjunctivitis, diplopia, optic neuritis. **Hematologic:** Hemolytic anemia, thrombocytopenia, granulocytopenia, bleeding episodes. **Allergic:** Fever, serum sickness, lupus erythematosus syndrome. **Endocrine:** Gynecomastia, hypoglycemia. **Cardiovascular:** Arrhythmias. **Renal:** Decreased creatinine clearance, polyuria, azotemia.

Overdosage: In cases of acute overdosage, the stomach should be emptied. The drug is acidic and excreted in the urine, so alkaline diuresis may be beneficial.

Dosage and Administration: Rheumatoid arthritis and osteoarthritis, including flares of chronic disease: Suggested dosage is 300, 400 or 600 mg t.i.d. or q.i.d.

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MED B-4-S

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FOR: John M. Malone, MD, Chairman
MSMS Judicial Commission

"Is it proper for a physician to send a patient's medical records, at the patient's request, to paramedical groups who will be providing the patient with physical therapy? Most often these groups are private companies owned and operated by paramedical personnel and the patients usually are with workmen's compensation plans or insurance companies and have been referred by their carriers to a rehabilitation group."

The MSMS Judicial Commission has discussed this matter with MSMS legal counsel and decided that the physician, indeed, must send medical information if the patient sends in a written authorization to release the information.

If the record is of great size, the Judicial Commission and legal counsel agree, it is appropriate for the physician to charge a modest fee for making copies. The record is generally taken to mean the things in the patient's file, excluding personal and family notes.

"Would the MSMS Judicial Commission please comment on whether there are any legal and legitimate methods by which physicians might write back-to-work slips for our patients who we do not feel would otherwise require an office visit? We are speaking, for instance of chronic migraine headache sufferers, or victims of influenza outbreaks. We do not feel every illness that may lead to work loss necessitates a costly visit to the physician's office. Yet, in our community, many of the factories and businesses require back-to-work slips from the patient before he or she is allowed to return to the job."

The Judicial Commission considered both these questions carefully and came to the conclusion that a physician should always see a patient before issuing a work excuse. The Commission believes the two problems mentioned are essentially a problem for the employer and a management decision must be made. The Commission suggested, however, that in cases where a chronic illness is diagnosed, such as migraine, the physician may wish to write a letter to the company stating the nature of the illness and indicating that its recurrence will not require medical attention. (This, of course, must be done only with the written consent of the patient.) Then the employer will be able to make the appropriate management decision for this special circumstance.

HEALTH PLANNING UPDATE

**By Dennis Paradis, Director
MSMS Physician/HSA Support Center**



Come to health planning meeting!

The MSMS Steering Committee on Health Planning invites MSMS members to attend a CME course on health planning.

"Health Planning: Impact on the Physician and on Patient Care" is the title of the course, which is being offered during the MSMS Annual Scientific Meeting. The course is scheduled Wednesday Nov. 19 at 8:30 a.m. at the Hyatt Regency Dearborn. It is approved for three (3) Category I CME credits.

The course will present the background of health planning at the federal and state level. Fundamentals will be described, as well as the role played by each segment of the health planning structure. Specifics will follow the physicians' responsibilities. The course is to conclude

with the theoretical and actual impact of health planning on the patient.

The course is being directed by Maurice Reizen, MD, director, Michigan Department of Public Health.

Speakers include:

Dennis M. Paradis, MPH, East Lansing, MSMS coordinator for Health Planning, who will present a slide/tape show on the structure and function of the health planning process;

Kenneth J. Ray, MD, Trenton chairman, MSMS Steering Committee on Health Planning, who will speak on the development of health planning as a tool to mold the health care delivery system.

Hermann A. Ziel, Jr., MD, Lansing chief, Health Care Administration, Michigan Department of Public Health, who will speak on the use of regulation in enforcing health planning decisions.

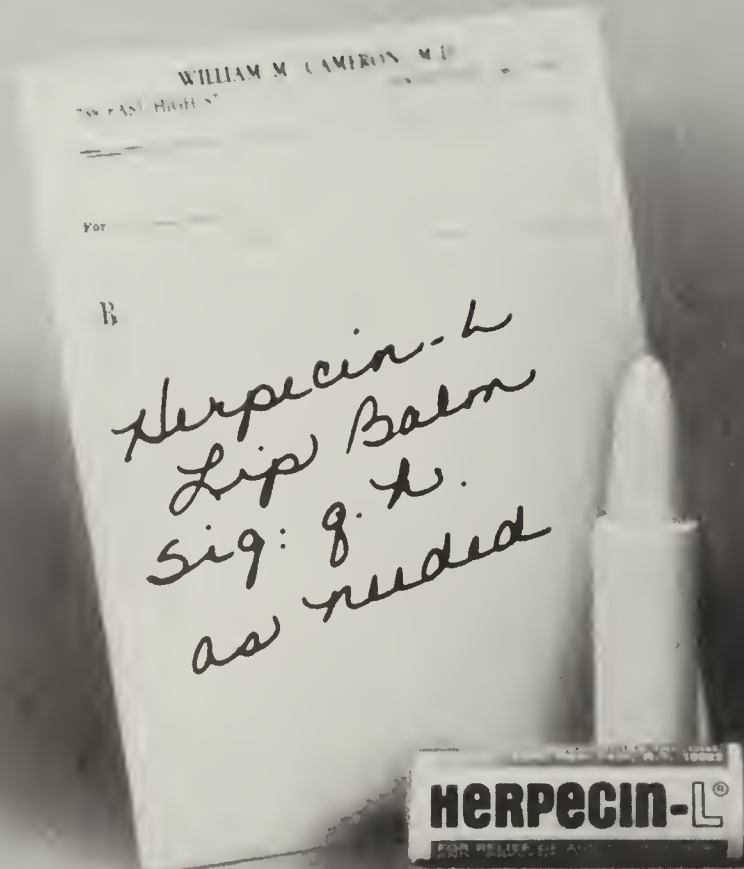
James D. Fryfogle, MD, MSMS President-Elect and chairman of the Seven-County Health Planning Advisory Committee, who will speak on the role of the physician in the health planning process;

Rev. Terry C. Daly, Muskegon, chairman, Statewide Health Coordinating Council, who will discuss the consumer perspective and participation in health planning.

Robert J. Toteff, MD, Saginaw vice-chairman, Statewide Health Coordinating Council and member, MSMS Steering Committee on Health Planning, who will address the impact of health planning on patient care.

The course is sponsored by the Michigan Department of Public Health and the MSMS Physician/HSA Support Center.

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must What you should know about the Michigan Drug Substitution law

The state legislature has dramatically changed the lawful way of prescribing drugs and of writing a prescription. Until now, writing the brand name of a drug on the prescription was enough to ensure that the brand-name drug would

indeed be dispensed. Now that no longer suffices. Unless the physician takes the necessary extra steps, for many drugs the pharmacist may substitute an "equivalent" generic drug.

Key points for the physician in writing prescriptions

- The pharmacist shall not dispense a generically equivalent drug product if:
 - (a) The prescriber, in the case of a prescription in writing signed by the prescriber, writes in his own handwriting "dispense as written" or "D.A.W." on the prescription.
 - (b) The prescriber, having pre-printed on his prescription blanks the statement "another brand of a generically equivalent product, identical in dosage, form, and content of active ingredients, may be dispensed unless initialed "D.A.W."; writes the initials "D.A.W." in a space, box, or square adjacent to such statement.
 - (c) The prescriber, in the case of a prescription other than one in writing signed by the prescriber, expressly indicates the prescription is to be dispensed as communicated.

Rx

D.A.W.

Signature

The decisions the physician must make

The physician should acquaint himself with the newly mandated prescription language illustrated on the preceding page. This requires a distinct change from the way prescriptions were previously written.

The prescription may be filled generically unless the physician writes in his own handwriting "D.A.W." or "Dispense As Written." Only by adding this language can the physician ensure that the brand-name drug will be dispensed.

If the physician elects to permit substitution, no special indication need be made, since unless explicitly prohibited the pharmacist may substitute.

MSD

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MSMS seeking new legislation to mandate Medicaid peer review system

By Ellen Vinocur Potash, MSMS Assistant for Public Policy

In an effort to assure high quality care, as well as to save money in the Medicaid program, the Michigan Department of Social Services has attempted to control provider fraud and abuse through departmental policy.

According to MDSS, this has been an adequate approach in cases of providers who inadvertently overbill the program.

However, the providers who intentionally defraud the program have been successfully challenging in court the authority of the Department to prosecute based on informal policy alone. MDSS believes that giving statutory authority to the Department to enforce policy would deter providers from intentional abuse and fraud.

House Bill 5868 is a legislative attempt to specify responsibility for the administration of the Medicaid program. The Act will give the force of law to what are essentially current policies, procedures and conditions of provider participation in the Medicaid program.

In May 1975, the MSMS Council adopted the following resolution:

"That the Michigan State Medi-

cal Society strongly support the Michigan Department of Social Services in its efforts to limit abuse of the Medicaid program through medical and financial audit of providers with a demonstrated pattern of overutilization; and further that MSMS Judicial Commission be requested to take appropriate action against MSMS members who abuse the program and that MSMS request the Michigan Medical Practice Board to investigate and take action against abusers of the Medicaid program who are not members of MSMS."

Since 1977, MSMS has recommended physicians in 12 specialties to work with MDSS to identify providers who are overusing the Medicaid program. This peer review effort is directed towards questions of quality or appropriateness of service which can best be resolved by health care professionals.

Gerald Mandell, MD, chairman, MSMS Task Force on Fraud and Abuse, has been a leader in the effort to assist the MDSS in its fight against misuse and abuse. Doctor Mandell has been an active volunteer partici-

pant in the peer review process since its inception in 1977.

MSMS analysis of HB 5868 indicates the proposed bill recognizes this existing peer review system, but does not mandate the system's role in MDSS decision making. Through the combined efforts of Doctor Mandell, MSMS, MDSS and the Michigan Attorney General, amendments have been offered to the bill which will increase the role of this peer review mechanism to the extent that it would be the basis for all MDSS determinations of medical necessity and appropriateness.

MSMS also is concerned with language in the bill which stipulates that if a provider fails to notify the MDSS of an overpayment, such failure would "constitute a conversion of the money by the provider."

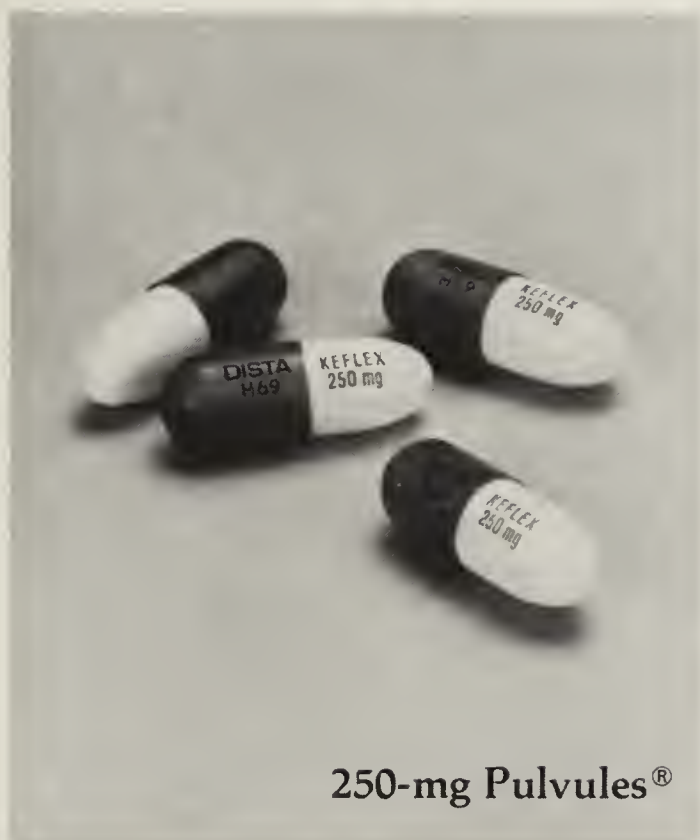
The language would mean that "failure to notify" could be considered the criminal offense of fraud. Proposed amendatory language which states that "a consistent pattern of failure to notify the director shall constitute a conversion of money by the provider" has been recommended to the legislature. The amendment will protect from criminal prosecution the provider who inadvertently receives overpayment.

On Sept. 24, the MSMS Committee on State Legislation and Regulations acted to seek additional amendments to HB 5868 which will be submitted in writing to the Senate Committee on Health and Social Services, chaired by Senator Edward Pierce. On Sept. 26, Doctor Mandell traveled to Lansing to address the peer review issues of the bill with the Senate Committee. At the brief hearing, Doctor Mandell reiterated the MSMS position supporting the effort to curb Medicaid fraud and abuse and accepted the offer of Senator Pierce to return at a later date to discuss the issue more fully. Please watch for further news in upcoming issues of Michigan Medicine.

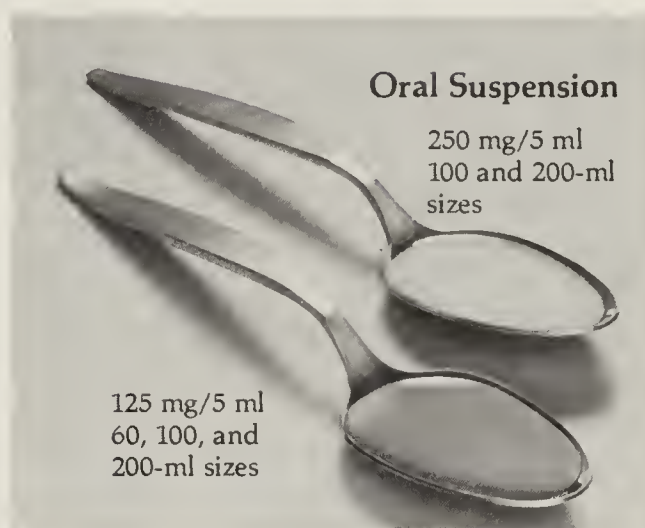


New Wayne County Medical Society President Kenneth J. Ray, MD, Trenton, is flanked by MSMS Council Chairman Louis R. Zako, MD, left, and MSMS President John R. Ylvisaker, MD, at recent installation ceremonies.

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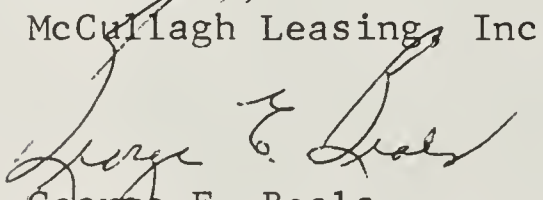
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Once again, thank you for your continued confidence and participation.

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Michigan Board of Medicine disciplinary actions

The following actions of the Michigan Board of Medicine were taken following investigation and appropriate administrative action, are printed from official memoranda to MSMS and are not editorialized:

June 17 to Aug. 12

NAME & ADDRESS	DATE & ACTION TAKEN	VIOLATION
Max J. Pierson, MD 16189 Oxley, Apt. #201 Southfield, MI 48075 License #011618	6-4-80 License Surrendered (Permanently)	Obtaining, possessing or attempting to obtain or possess a controlled substance without lawful authority. Selling, prescribing, giving away, or administering drugs for other than lawful diagnostic or therapeutic purposes. Personal disqualifications consisting of incompetence.
Mehmet Kusun Kasal, MD 4433 Buttercup West Traverse City MI 49684 License #031265	May 15, 1980 Revoked effective 6-27-80	Failure to use reasonable care and discrimination in the administration of drugs and failure to employ acceptable scientific methods in the selection of drugs or other modalities for treatment of disease. Selling, prescribing, giving away or administering drugs for other than legal and legitimate therapeutic purposes. Lacking good moral character. A departure from, or the failure to conform to, minimal standards of acceptable and prevailing medical practice, whether or not actual injury to a patient is established.
Joan H. Shapiro, MD 280 N. Woodward Ave. #218 Birmingham, MI 48011 License #033919	August 6, 1980 Suspension from 2-6-80 to 2-6-81	A violation of general duty, consisting of negligence or failure to exercise due care, including negligent delegation to or supervision of employees or other individuals whether or not injury results or any conduct, practice, or condition which impairs, or may impair, the ability to safely and skillfully practice the health profession. Substance abuse as defined in Section 6107. Mental or physical inability reasonably related to and adversely affecting the licensee's ability to practice in a safe and competent manner.

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PERSPECTIVES IN SURGERY

Wednesday,
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ADOLESCENT GYNECOLOGY & OBSTETRICS

Wednesday,
March 4, 1981

PEDIATRIC SEMINAR V

Wednesday,
April 15, 1981

FAMILY PRACTICE UPDATE

Wednesday,
May 20, 1981

All programs approved for
eight (8) hrs. cr. in Category I.

For information contact:
Ms. Linda Radu (313) 343-3877

continued on page 596

Michigan fourth among all states in million dollar jury verdicts

Michigan is fourth highest among all the states in number of million dollar jury verdicts, according to Jury Verdict Research, Solon, Ohio, a consulting firm.

Michigan has had 32 such seven-figure verdicts since juries first began awarding such amounts in 1962. California leads the nation with 59, Florida is second with 46 and New York is third with 42. Texas, Illinois and Pennsylvania trail Michi-

gan with 21, 19 and 11 such awards, respectively.

Since 1962, there have been 385 awards made of over \$1,000,000, according to the research company's report in The State Bar of Michigan newsletter.

The State Bar's "Newsbriefs" notes that inflation accounts for the increase in size and number of awards. Catastrophic injuries such as brain damage, quadriplegia, para-

plegia, missing limbs and scarring burns result in long-term care of 20 to 30 years. Hence, money must be there past the year 2000, when costs may have skyrocketed. The article also notes that the giant jury awards often are reduced by the court on motion or appeal.

The Jury Verdict Research report covers all large awards including manufacturer's liability judgements, and does not involve medical malpractice alone. In fact, the largest awards have been in the area of product liability.

On the medical malpractice legal front, the State Bar of Michigan's "Newsbriefs" newsletter also reports the Florida legislature has enacted a law which requires the losing party in a medical malpractice case to pay the adversary's attorney fees.

The Florida Medical Association supported the new law, which became effective July 1, according to "Newsbriefs."

Under the new law, the recovery of attorney fees applies only to malpractice suits against MDs, osteopathic physicians, podiatrists, hospitals and HMOs. The lawyer must inform his client — in writing — of the statute's provisions before the client files suit. The original bill applied to all types of civil litigation, but ran into strong opposition.

BOARD OF MEDICINE/continued

Name & Address	Date & Action Taken	Violation
George A. Ellis, MD 7263 Gratiot Road Saginaw, MI 48603 License #030626	August 6, 1980 Letter of Reprimand	Failure to use reasonable care and discrimination in the administration of drugs, and failure to employ acceptable scientific methods in the selection of drugs or other modalities for treatment of disease. Selling, prescribing, giving away, or administering drugs for other than legal and legitimate therapeutic purposes. A departure from, or the failure to conform to, minimal standards of acceptable and prevailing medical practice, whether or not actual injury to a patient is established.
William J. Mosee, MD 2432 W. Boston Boulevard Detroit, MI 48206	August 6, 1980 Suspended from 8-6-80 to 8-6-81 Probation from 8-6-81 to 8-6-86 (Suspension is for a minimum of 1 year)	Incompetence. Obtaining, possessing, or attempting to obtain or possess a controlled substance as defined in section 7104 without lawful authority; or selling, prescribing, giving away, or administering drugs for other than lawful diagnostic or therapeutic purposes. A violation, or aiding or abetting in a violation, of this article or of rules promulgated under this article.



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Meticorten (prednisone) Schering Corporation
Anturane (sulfapyrazone) Ciba-Geigy Corporation
Erythrocin (erythromycin) Abbott Laboratories

Research and development, the life blood of pharmacotherapeutic progress

The drugs that have contributed so much to modern medicine were the product of long years of expensive research. And tomorrow's drugs depend upon continuation of the research and development going on right now. The cost of that research is one of the things reflected in the price of a brand-name drug. The substitution of a cheaper "generic" drug for a brand-name product may save the patient some money at the prescription counter. However, it threatens the very foundations of modern pharmaceutical research.

The hidden cost of "cheaper" generic drugs

Much of the enthusiasm for generic prescribing is based on a shortsighted view that fails to take such long-term issues into account. While cost is an important factor, pharmaceutical research, the quality of medicine, and future generations of patients must all be considered.

Settling for cheaper drugs today could deprive you and your patients of the drugs they may need tomorrow.



To encourage imitation is to discourage innovation

NEW MEMBERS

Members of the Michigan State Medical Society join in welcoming the following new members into a progressive state medical organization. MSMS is dedicated to promoting the science and art of medicine, the protection of the public health, and the betterment of the medical profession. Each new member is encouraged to join with other MSMS members at both the local and state levels in achieving these goals.

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Bronson Methodist Hosp. Kalamazoo, 49007	
Kirk J. Agerson, MD	FP
2410 Gaynor Ave., NW Grand Rapids, 49504	
Jawaid Akhtar, MD	CRS/GS
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9433 Joseph Campau Hamtramck, 48212	
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2550 Niles Rd. St. Joseph, 49085	

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35 Kirby Ct.
Grosse Pte. Farms, 48236

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153 Lafayette, SE
Grand Rapids, 49503

Arnold M. Berman, MD
35 S. Johnson
Pontiac, 48053

Donna J. Blair, MD
2631 Bennet
Dearborn, 48124

Suresh A. Bharani, MD
21438 Dequindre #101
Warren, 48091

Mohinder S. Chadha, MD
814 S. Main 3-F
Adrian, 49221

Bong Whan Chang, MD
15101 Southfield Rd.
Allen Park, 48101

Michael K. Conley, MD
1414 W. Fair Ave. #255
Marquette, 49855

Farid A. Damian, MD
21331 Kelly Rd.
East Detroit, 48201

Alexander A. Dekovich, MD
108 S. First St.
Alpena, 49707

Guy H. Earle, MD
128 Michigan Ave.
Gladstone, 49837

Nancy Eos, MD
1301 Orleans, E. #418
Detroit, 48207

Edwidge Eugene, MD
19601 Greenwald Dr.
Southfield, 48075

George A. Ferre, MD
170 S. Howell St.
Hillsdale, 49242

Faith B. Fritsch, DO
13109 Shavey Rd. #7
DeWitt, 48820

Douglas A. Furman, MD
5304 S. Straits Hwy.
Indian River, 49749

Jose R. Ganata, Jr., MD
3245 E. Jefferson
Detroit, 48207

Joyce M. Geary, MD
3424 Davenport
Saginaw, 48602

continued on page 600

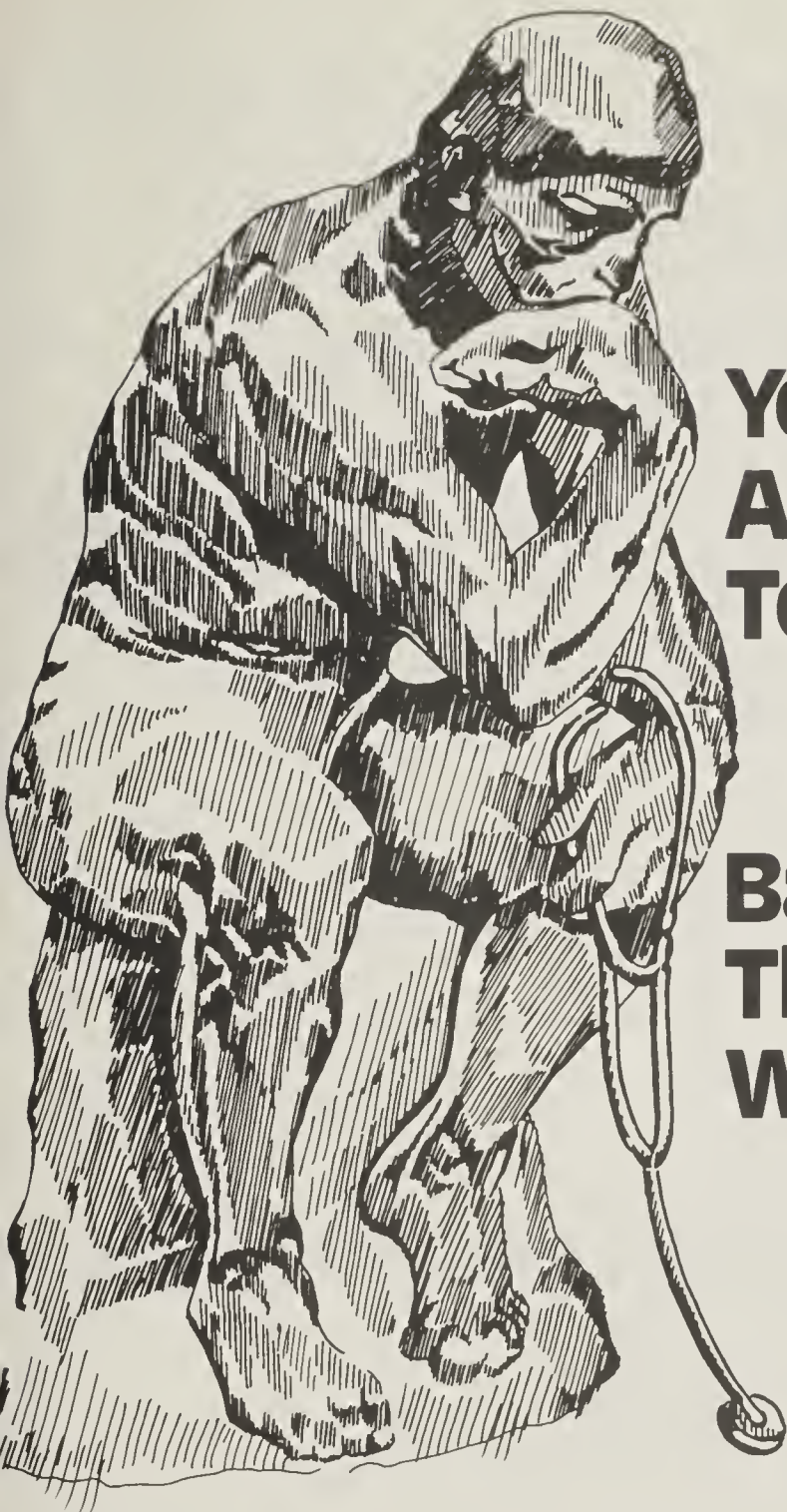
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Francis Bell Mem. Hosp.
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Jean D. Pierre-Louis, MD GP
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Plymouth, 48170

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continued on page 602

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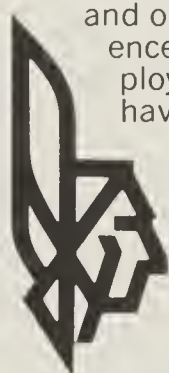
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MEETINGS

MSMS, MSMS/A, AMA and medical assistants

Nov. 18-20 — MSMS Annual Scientific Meeting, Hyatt Regency Dearborn, contact: Sherry Fent, MSMS headquarters.

Dec. 3 — MSMS Council, MSMS headquarters, contact: Warren Tryloff, MSMS headquarters.

Dec. 7-10 — AMA House of Delegates, San Francisco, contact: AMA, 535 N. Dearborn St., Chicago, 60610.

Jan. 4-7, 1981 — Seventh AMA State Health Legislation Meeting, Sonesta Beach Hotel and Tennis Club, Key Biscayne, FL, contact: Department of State Legislation, AMA, 535 N. Dearborn St., Chicago, 60610

Jan. 21, 1981 — MSMS Council, MSMS headquarters, contact: Warren Tryloff, MSMS headquarters.

Jan. 26, 1981 — MSMS/A Mid-year Board Meeting, MSMS headquarters, contact: Caroline Rich, MSMS headquarters.

Jan. 31-Feb. 1, 1981 — Mid-Winter Seminar, State of Michigan Branch, American Association of Medical Assistants, Benton Harbor, contact: Caroline Rich, MSMS headquarters.

Feb. 10-11, 1981 — MSMS/Physician Service Group, Inc. Practice Management Seminar, Long's Convention Center, Lansing, contact: Meredith Fors, MSMS headquarters.

Feb. 12-13, 1981 — MSMS/Physician Service Group, Inc. Practice Management Seminar, Michigan Inn, Southfield, contact: Meredith Fors, MSMS headquarters.

Feb. 20-Mar. 7, 1981 — MSMS/Intrav South African Adventure, contact: Marcelyn Ireland, MSMS headquarters. 517/337-1351.

Mar. 11, 1981 — MSMS/A Legislative Day, Civic Center, Lansing, contact: Caroline Rich, MSMS headquarters.

Apr. 23-26, 1981 — State Convention, State of Michigan Branch, American Association of Medical Assistants, Hilton, Lansing, contact: Caroline Rich, MSMS headquarters.

April 27-29, 1981 — MSMS/A 55th Annual Convention, Marriott, Grand Rapids, contact: Caroline Rich, MSMS headquarters.

Other meetings

Nov. 18 — Membership Meeting, Michigan Otolaryngological Society, Hyatt Regency Dearborn, contact: Ronald Bogdasarian, MD, ENT Department, Wayne County General Hospital, 2345 Merriman Rd., Westland, 48185.

Nov. 19 — Annual Membership Meeting, Michigan Society of General Surgeons, Hyatt Regency Dearborn, contact: Caroline Rich, MSMS headquarters. 517/337-1351.

Nov. 19 — Business Meeting, Michigan Society of Colon and Rectal Surgeons, Hyatt Regency Dearborn, contact: Robert E. McKnight, MD, 15901 West Nine Mile Road, Southfield, 48075.

Nov. 19 — Business Meeting, Michigan Dermatological Society, Hyatt Regency Dearborn, contact: Alejan-

dro Morales, MD, 1015 Fernwood, Royal Oak, 48067.

Nov. 20 — Membership meeting, Michigan Chapter, American College of Chest Physicians, Hyatt Regency Dearborn, contact: Marcelyn Ireland, MSMS headquarters. 517/337-1351.

Jan. 22, 1981 — Council Meeting, Michigan Psychiatric Society, Hyatt Regency Dearborn, contact: Helen Schulte, MSMS headquarters.

Jan. 16, 1981 — Annual Membership Meeting, Michigan Ophthalmological Society, Wayne County Medical Society, Detroit, contact: Margot Surridge, Executive Secretary, 313/839-3011.

April 30, 1981 — Annual Meeting, Michigan Society of Thoracic Surgeons, Hyatt Regency Dearborn, contact: Rodman E. Taber, MD, 30050 Hoover Road, Warren, 48093.

NEW MEMBERS/continued

Mark Takagishi, MD PD
2700 Geert Ct.
Lansing, 48910

Douglas M. Van Drie, MD OBG
1900 Wealthy St., SE
Grand Rapids, 49506

David H. Van Dyke, MD N
1900 Wealthy St., NE
Grand Rapids, 49506

P.F. Dirk Van Peenen, MD GPM
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Midland, 48640

John R. Venable, MD OM
2701 Mt. Vernon Dr.
Midland, 48640

Douglas C. Westveer, MD IM/CD
Wm. Beaumont Hospital
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Ephraim C. Ahanonu, MD OBG
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Oak Park, 48237

Lal Gopal Banerji, MD IM
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Petoskey, 49770

Alfred E. Feleppa, Jr., MD ENT
1217 Crystal Lake
Iron Mountain, 48901

Virginia B. Feleppa, MD IM/ON

800 East Blvd.
Kingsford, 49801

George W. Gibson, DO OBG
15201 W. McNichols
Detroit, 48235

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30642 Schoolcraft Rd.
Livonia, 48150

Robert G. Hylland, MD IM/RHU
1675 Leahy #236
Muskegon, 49442

Ashok S. Karnik, MD PUD/IM
16 Stratford Place
Grosse Pte., 48230

James F. Lininger, MD PTH
1521 Gull Rd.
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Canton, 48187

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Midland, 48640

Edward R. Teitel, MD EM
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CATEGORY I COURSES

Michigan Medicine each month carries a list of opportunities in Michigan for doctors of medicine to obtain Category I credit toward meeting the requirements of Michigan law. Sponsors of Category I programs and courses in Michigan are invited to submit information for the monthly calendar.

Each listing below, of programs that carry at least 3 hours of Category I credit, indicates a contact person, so the physician can obtain details. Physicians with questions about accredited programs may phone MSMS Headquarters, 517/337-1351.

Date: Nov. 12, 20th Annual Thyroid Workshop. **Location:** Scott Hall, Detroit Medical Center. **Sponsor:** Wayne State University Office of CME. **For:** All interested physicians. **Contact:** Ms. Anita Tompkins, 313/577-1180. **Approved for:** 6 hours of Category I Credit.

Date: Nov. 13-14, Seminar on Quality Assurance. **Location:** Detroit. **Sponsor:** Joint Commission on Accreditation of Hospitals. **Co-Sponsor:** Michigan Hospital Association. **For:** Hospital management, medical and nursing staffs. **Contact:** Maryanne Butt, Michigan Hospital Association, 2213 E. Grand River, Lansing, 48912, 517/484-7441. **Approved for:** 11 hours of Category I Credit.

Date: Nov. 14-15, Twenty-Eighth Annual Symposium on Trauma. **Location:** Harper Hospital, Kresge Auditorium, Detroit. **Sponsor:** Michigan Committee on Trauma of the American College of Surgeons and the Department of Surgery of Wayne State University. **For:** All interested physicians. **Cost:** Physicians — \$60.00, Residents — \$30.00. **Contact:** Charles E. Lucas, MD, Chairman, 313/494-3485. **Approved for:** 9 hours of Category I Credit.

Date: Nov. 17-18, Treatment of Injuries of the Hand: Primary and Definitive Care. **Location:** Detroit Plaza Hotel. **Sponsor:** Wayne State University School of Medicine, Department of Surgery and American Society for Surgery of the Hand. **For:** All interested physicians. **Cost:** \$250. **Contact:** Gerald F. Prieur, Jr., MPA, Wayne State University School of Medicine, Continuing Medical Education, 9B-32 Health Care Institute, Detroit, 48202, 313/577-1180. **Approved for:** 19 hours of Category I Credit.

Date: Nov. 18-20, MSMS Annual Scientific Meeting. **Location:** Hyatt Regency Dearborn. **Sponsor:** Michigan State Medical Society. **For:** All interested physicians. **Contact:** Sherry Fent, MSMS, 517/337-1351. **Approved for:** 18 hours of Category I Credit.

Date: Nov. 28- Dec. 2, Ophthalmology: Basic and Clinical Review. **Location:** Hyatt Regency Dearborn. **Sponsor:** Wayne State University School of Medicine and Kresge Eye Institute. **For:** All interested physicians. **Contact:** Gerald F. Prieur, Jr., MPA, Program Coordinator, 313/577-1180. **Approved for:** 42 hours of Category I Credit.

Date: Dec. 3, Perspectives In Surgery. **Location:** Saint John Hospital, Detroit. **Sponsor:** Saint John Hospital. **For:** All interested physicians. **Cost:** \$100. **Contact:** Ms. Linda Radu, Office of CME, Saint John Hospital, 22101 Moross Rd., Detroit, 48236. 313/343-4000. **Approved for:** 8 hours of Category I Credit.

Date: Dec. 5-6, Immunology and Allergy Review. **Location:** Scott Hall, Detroit Medical Center. **Sponsor:** Wayne State University Office of CME. **For:** All interested physicians. **Contact:** Ms. Anita Tompkins, 313/577-1180. **Approved for:** 9½ hours of Category I Credit.

Date: Dec. 6, The Cancer Patient: An Interdisciplinary Approach. **Location:** Henry Ford Hospital, Detroit. **Sponsor:** Henry Ford Hospital. **For:** All interested physicians. **Contact:** Office of Medical Education, Henry Ford Hospital, 2799 W. Grand Blvd., Detroit, 48202. 313/876-1463. **Approved for:** 6½ hours of Category I Credit.

Date: Dec. 6, 1980, Practical Management of Common Neurosurgical Problems. **Location:** Borgess Medical Center, Kalamazoo. **Sponsor:** Neurosurgery of Kalamazoo, P.C. and Borgess Medical Center. **Co-Sponsor:** Southwestern Michigan Area Health Education Center. **For:** All interested physicians. **Cost:** \$25. **Contact:** Charles L. Zeller, Jr., MD, SMAHEC, 252 E. Lovell, Kalamazoo, 49007. **Approved for:** 6 hours of Category I Credit.

Date: Dec. 13, General Pathologic Problems Encountered in the Practice of Forensic Pathology. **Location:** Towsley Center, Ann Arbor. **Sponsor:** Michigan Society of Pathologists. **For:** Pathologists. **Contact:** T. A. Reyman, MD, Department of Pathology, Mt. Carmel Mercy Hospital, Detroit, 48235. **Approved for:** 3 hours of Category I Credit.

Date: Jan. 21, 1981, Current Advances in Hepatitis and Liver Diseases. **Location:** St. John

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Hospital, Detroit. **Sponsor:** St. John Hospital. **For:** All interested physicians. **Cost:** \$100. **Contact:** Ms. Linda Radu, Continuing Medical Education, 313/343-3877. **Approved for:** 8 hours of Category I Credit.

Date: Feb. 14, 1981, **A Practical Endocrinologic Approach for the Diagnosis of Thyroid and Adrenal Disorders.** **Location:** Henry Ford Hospital, Detroit. **Sponsor:** Michigan Society of Pathologists. **For:** All interested physicians. **Contact:** T. A. Reyman, MD, Department of Pathology, Mt. Carmel Mercy Hospital, Detroit, MI 48236. **Approved for:** 3 hours of Category I Credit.

Date: Feb. 18-19, **Problems & Perspectives in Pulmonary Infections.** **Location:** Boyne Highlands. **Sponsor:** Henry Ford Hospital. **For:** All interested physicians. **Contact:** Office of Medical Education, Henry Ford Hospital, 2799 W. Grand Blvd., Detroit, 48202, 313/876-1463. **Approved for:** 7 hours of Category I Credit.

Date: Feb. 20-22, 1981, **Practical Otolaryngology.** **Location:** Dearborn Inn, Dearborn. **Sponsor:** Wayne State University Office of CME. **For:** All interested physicians. **Contact:** Ms. Anita Tompkins, 313/577-1180. **Approved for:** 12 hours of Category I Credit.

Date: March 4, 1981, **Adolescent Gynecology and Obstetrics.** **Location:** St. John Hospital, Detroit. **Sponsor:** St. John Hospital. **For:** All interested physicians. **Cost:** \$100. **Contact:** Ms. Linda Radu, Continuing Medical Education, 313/343-3877. **Approved for:** 8 hours of Category I Credit.

Date: April 1-4, 1981, **Aesthetic and Reconstructive Surgery of the Head and Neck.** **Location:** Campus Inn, Ann Arbor. **Sponsor:** Department of Otolaryngology, University of Michigan Medical Center. **For:** All interested physicians. **Cost:** \$500. **Contact:** Shan R. Baker, MD, Dept. of Otolaryngology, University of Michigan Medical Center, Ann Arbor, 48109.

Patients needed for U-M research on islet cell tumors of the pancreas

Cooperation of internists, surgeons and radiologists is requested in the referral of patients with the proven or strongly suspected diagnosis of islet cell tumors of the pancreas (insulinoma, glucagonoma, gastrinoma, and "nonfunctioning" tumors), carcinoid tumors, or adenocarcinoma. Studies will include specific diagnostic studies, tumor localization studies —

Approved for: 28 hours of Category I Credit.

Date: April 15, **Pediatric Seminar V.** **Location:** Saint John Hospital, Detroit. **Sponsor:** Saint John Hospital. **For:** All interested physicians. **Cost:** \$100. **Contact:** Ms. Linda Radu, Office of CME, Saint John Hospital, 22101 Moross Rd., Detroit, 48236. 313/343-4000. **Approved for:** 8 hours of Category I Credit.

Date: May 20, **Family Practice Update.** **Location:** Saint John Hospital, Detroit. **Sponsor:** Saint John Hospital. **For:** All interested physicians. **Cost:** \$100. **Contact:** Ms. Linda Radu, Continuing Medical Education, 313/343-3877. **Approved for:** 8 hours of Category I Credit.

Date: Aug. 18-21, **Michigan Health Officers Association Annual Meeting.** **Location:** Holiday Inn, Traverse City. **Sponsor:** Michigan Health Officers Association. **For:** All interested physicians and health officers. **Contact:** William W. Moon, MD, Box 43, Harrietta, 49638. **Approved for:** 5 hours of Category I Credit.

specifically transhepatic, transportal pancreatic venous catheterization — as well as basic physiologic and pharmacologic studies. Cost of research procedures will be borne by the Clinical Research Center of The University of Michigan and the Division of Endocrinology and Metabolism at The University of Michigan. In most circumstances patients will be admitted to the Clinical Research Center for approximately one week for full evaluation. Specific tests can be done, when appropriate, during shorter admissions or as outpatients. Patients need not submit to full investigation to qualify for participation.

Physicians interested in more information should contact Arthur Vinik, MD, 313/763-5352 or Benjamin Glaser, MD, Division of Endocrinology and Metabolism, The University of Michigan Medical Center, C7009 Outpatient Building, Box 02, Ann Arbor, 48109 (313) 764-4162.

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DEATHS



Warren F. Belknap, MD Troy

Warren F. Belknap, MD, died July 31 at the age of 70. Doctor Belknap received his MD from Loyola University School of Medicine in 1937. He received his pediatric training at Children's Hospital of Michigan. At the time of his death Doctor Belknap was a staff member of Beaumont Hospital in Royal Oak.

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Howard B. Burnside, MD Southfield

Howard B. Burnside, MD, died July 26. He was 79. Doctor Burnside earned his MD from Wayne State University School of Medicine and served four years with the U.S. Army during World War II. He was a member of the American College of Radiologists and maintained a radiology practice in Royal Oak until his retirement in 1974.

Mario S. Cioffari, MD Royal Oak

Mario S. Cioffari, MD, Royal Oak, died Sept. 12 at the age of 73. Doctor Cioffari received his MD from Cornell Medical School. He was emeritus staff physician at Providence, Mt. Carmel, Grace and Mt. Sinai hospitals and Children's Hospital of Michigan. Doctor Cioffari was a past president of the Detroit Pediatrics Society and a member of the Michigan Academy of Pediatrics, the Michigan Allergy Society and the Perinatal Mortality Society.

John Lewis Dill, MD Boca Raton, FL

John Lewis Dill, MD, Boca Raton, FL, died Aug. 13. He was 80. Doctor Dill was chairman of the otolaryngology department at Henry Ford Hospital until his retirement in 1970. He earned his MD from the University of Toronto in 1925. He was a member of the Triological Medical Society, Detroit Otolaryngological Society and the John Hopkins Surgical and Medical Association.

Robert J. Elvidge, MD Grosse Pointe Farms

Robert J. Elvidge, MD, Grosse Pointe Farms, died July 11 at the age of 82. Doctor Elvidge received his MD from the Detroit College of Medicine, now known as Wayne State University School of Medicine. He was a former chief of staff of internal medicine at Grace Hospital.

Henry C. Gomley, MD Bronson

Henry C. Gomley, MD, Bronson, died Aug. 15 at the age of 63. Doctor Gomley received his MD from the Univer-

sity of Michigan Medical School in 1942. He served with the U.S. Navy during World War II as a lieutenant commander. He maintained a private practice in Bronson for 30 years and was president of the Branch County Medical Society.

Howard T. Howlett, MD Birmingham

Howard T. Howlett, MD, Birmingham, died July 30. He was 77. Doctor Howlett served on the staff of Grace Hospital, was chairman of the executive committee from 1964 to 1966 and was chief of staff for many years. He earned his MD from the University of Michigan Medical School in 1928. He was a member of the Wayne County Ethics Committee and past president and secretary of the Detroit Academy of Surgery.

Robert M. Jennings, MD Madison, WI

Robert M. Jennings, MD, Madison, WI, died July 19. He was 73. Doctor Jennings received his MD from the University of Michigan Medical School in 1933. He served as a psychiatrist with the state hospital in Kalamazoo for 27 years. He retired in 1969.

Seyed A. M. Kazerooni, MD Bloomfield Hills

Seyed A. M. Kazerooni, MD, Bloomfield Hills, died July 14 at the age of 48. Doctor Kazerooni earned his MD from Sheffield University School of Medicine in England. He served on the staffs of Pontiac General and Crittenton hospitals.

Lynford Miller, MD Adrian

Lynford Miller, MD, Adrian, died July 29. He was 78. Doctor Miller received his MD from Wayne State University School of Medicine in 1935. He was a fellow of the American Society of Abdominal Surgeons and acted as medical director of the Tecumseh Fisher Body plant until his retirement.

continued on page 608



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**James T. Klomparens, MD
Ada**

James T. Klomparens, MD, Ada, died Aug. 26. He was 53. Doctor Klomparens earned his MD from the University of Michigan Medical School in 1955. He joined the staff of St. Mary's Hospital in 1960 as an anesthesiologist. Doctor Klomparens was a member of the American Society of Regional Anesthesia, American Society of Anesthesiologists, and the American Professional Practice Association.

**Vasil P. Moisesides, MD
Grosse Pointe Woods**

Vasil P. Moisesides, MD, Grosse Pointe Woods, died July 26 at the age of 88. Before coming to the United States, he attended Anatolia College in Turkey and participated in the Panhellenic Games of 1912 for his college. Doctor Moisesides earned his MD from the University of Michigan Medical School in 1917. He was associated with Detroit Memorial Hospital until his retirement in 1972.

**Stanley L. Moleski, MD
Grand Rapids**

Stanley L. Moleski, MD, Grand Rapids, died Aug. 16 at the age of 75. Doctor Moleski was Grand Rapids city physician for 30 years, a former president of the Kent County Medical Society and chief of staff at St. Mary's Hospital from 1950 to 1952. He received his MD from Loyola University Medical School in 1931. He was a member of the American Board of Surgery, a fellow of the American College of Surgeons and a fellow of the International College of Surgeons.

**John W. Parnell, MD
Grosse Pointe Farms**

John W. Parnell, MD, Grosse Pointe Farms, died June 14. He was 72. Doctor Parnell received his MD from the Detroit College of Medicine in 1933. He was in the practice of internal medicine and was on the staffs of Holy Cross and St. Francis hospitals. He was a member of the American Diabetic Society, American Public Health Association, American Geriatric Society, and was a registered pharmacist.

**Vladimir Prokopowycz, MD
Bloomfield Hills**

Vladimir Prokopowycz, MD, Bloomfield Hills, died Sept. 3. He was 70. Born and raised in the Ukraine, Doctor Prokopowycz received his MD in 1935 from the University of Lviv. During World War II Doctor Prokopowycz was conscripted into the German army. Because of that military service, he later spent five years in a Soviet prisoner-of-war camp. Doctor Prokopowycz had maintained a private practice in Detroit since 1952.

**William G. Quigley, MD
Dexter**

William G. Quigley, MD, Dexter, died Sept. 8 at the age of 77. Doctor Quigley earned his MD from the University of Michigan Medical School in 1928. He was on staff for 40 years at Providence Hospital and chief surgeon for eight years. He was a member of the American College of Surgeons and the Detroit Surgical Society.

**Paul J. Rick, MD
Warren**

Paul J. Rick, MD, Warren, died Aug. 25. He was 78. Doctor Rick received his MD from the Detroit College of Medicine in 1929. He had maintained a private practice in Detroit for 25 years.

**C. Howard Ross, MD
Ann Arbor**

C. Howard Ross, MD, Ann Arbor, died Aug. 31 at the age of 90. Doctor Ross earned his MD from the University of Michigan Medical School in 1931. He maintained a private practice in Ann Arbor until his retirement in 1968. While beginning private medical practice, Doctor Ross served for four years as an instructor of internal medicine at the University of Michigan. He was a fellow of the American Geriatrics Society and was past president of the Michigan Academy of General Practice. He served at the White House Conference on Aging in 1971. Doctor Ross was a national board member and fellow of the American Medical Writers' Association. He was past president of the Northern Tri-State Medical Association and served as chairman of MSMS committees on CME and medical professional liability.

CLASSIFIED

The rate for each classified advertisement in *Michigan Medicine* is 15¢ per word, with a minimum charge of \$7.50. Copy for classified advertisements should be received not later than the first of the month preceding the month of publication.

Positions open

LOVELY SOUTHWESTERN CLIMATE — Excellent professional relationships — multispecialty group seeking an Internist. Contact — Talton Francis, El Paso Medical-Surgical Associates, PA, 10301 Gateway West, El Paso, Texas, 79925, phone 915/592-0201.

OBSTETRICIAN/GYNECOLOGIST, OPHTHALMOLOGIST, ORTHOPOD, PEDIATRICIAN — needed in historic Marshall, Michigan, located half-way between Ann Arbor and Kalamazoo. Beautiful town with a 77-bed acute care hospital. City population of 7,500 and service area population of 22,000. Admitting staff includes; four (4) Family Practice Specialists, five (5) General Practitioners, two (2) General Surgeons, and one (1) Internist. Willing to negotiate to attract a high caliber physician. Contact: Rob Covert, Administrator, or Philip Giotfelty, MD, Chief of Staff, Oaklawn Hospital, 200 North Madison, Marshall, Michigan 49068; or phone 616-781-4271, extension 201.

GP or FP for new clinic in the beautiful Black Hills. Ideal setting for many outdoor activities and a place to raise healthy children. Hospital with 49 beds, close association with large medical center. Primary care oriented group practice with starting salary \$40,000 plus health, life and malpractice insurance. Contact: Chris Lucas, MD, 209 N. 16th St., Hot Springs, SD, 57747. 605/745-3159.

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Positions With The State Of Michigan — Currently taking applications for positions expected to be available in the future. Primarily interested in board certified or board eligible internists with cardiology background. Office locations in Southfield, Lansing, and Traverse City. Also considering an office in Kalamazoo. Salary in 50's with approximately 40% fringe benefits. An equal opportunity employer. All enquiries treated confidentially. For further details please write: Disability Determination Service, P.O. Box 30011, Lansing, MI 48909, or call collect: Harry D. Nesmith, MD, Chief Medical Consultant (517) 373-7830. In Michigan, call toll free 1-800-292-2710.

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Commodity Resources, Inc.	604
CRT Management Co.	599
Detroit Bank and Trust	601
I. C. System	603
Eli Lilly	593
Marion Labs	569
McCullough Leasing	594
Medical Protective	600
Mediclinics, Inc.	598
Merck Sharp and Dohme ..	590, 591
Mercywood Hospital	607
Michigan Physicians Mutual Liability Company	589
Purepac	577
Roche ..	560, 561, 583, 597, IBC, BC
Saint John Hospital	595
Sandoz	567
Stat Medical Books	606
Stratton Cheeseman	581
Upjohn	584, 585, 586
U.S. Air Force	605
Wyeth Labs	573, 574



PRESIDENT'S PAGE

Guest column

Do you have solutions to stem rise in health care costs?

James D. Fryfogle, MD, MSMS president-elect

I have been asked to write the President's Page article this month. This will be a sort of preview by a pre-president about doctors, their art, their aspirations and their actions.

I've talked with docs at breakfast, lunch and dinner, in cloakrooms, in committees and in 28 House of Delegates meetings. That's a lot of talking. I would like any ideas expressed on this page to be considered my personal opinions tempered by those thousands of doctor conversations.

MSMS President Ylvisaker is concerned about reimbursement patterns and their effects on our practice. I share his concern and serve on his investigative committee. His President's page in the last three issues has shown you the broad outlines of his thinking. Please follow his series closely. It is one of the most important problems undertaken by your state medical society.

For my first plunge into this privileged page I'd like to introduce a subject that has frustrated almost every thinking doctor: the blame for the rising cost of medical care.

Between 1950 and 1974 total medical care costs rose 193 percent as compared to 114 percent for the consumers price index.

But to hold physicians, as "the brokers of services," totally responsible and to attribute rising costs to their ordering unnecessary medical services is simply not right. Nor are the approaches for containing this cost spiral by regulation (government) or by ra-

tioning of service (third party) having any success.

Let me today pose the problem as I see it and in the months ahead suggest possible solutions that doctors can support.

Premise:

There is no incentive to save money or contain the rising cost of health care in the US by patients (consumers), doctors or hospitals.

THE CONSUMER (patient) who earns "health dollars," has contributed to his health insurance plan for many years. When he is sick he wants the best treatment available and first-dollar coverage of its cost. How much it costs is of no concern since he believes "the insurance will pay for it."

THE PROVIDER (doctors, et al), whose income is largely dependent upon third party payments, i.e., health insurance companies, is penalized if he attempts to avoid or limit hospitalization of his patient. Hospitalization is the largest single expense in health care.

If the physician chooses to treat patients at home, the health insurance companies do not pay for house calls or office calls, and the patient is reluctant to pay for these services.

Also, small operations that could safely be done in the office are not paid for; therefore, the patient is sent to the hospital where the cost is many times greater.

The same is true for simple laboratory tests and procedures.

Besides coping with the pa-

tient's demand for the best treatment, the doctor must practice defensive medicine . . . and pay an excessive malpractice premium for fear of being sued.

Today's doctor has no incentive to save health dollars.

THE INSTITUTIONS (hospitals, et al) no longer are havens for the ill. They are a business. Their comptroller must deal with a horde of regulatory agencies that cut hospital spending programs, reduce bed capacity, and harass hospitals with certificates of need and other federal and state health planning rules and regulations. The comptroller's problem is not to save, but to maintain a cash flow that will keep the hospital afloat. The hospital needs the insurance and any other monies it can find.

What possible change can be made to alter these expensive attitudes? I believe there is only one, and we will get into it in detail in the months ahead.

If you have suggestions for this frustrating problem, please call or write me.

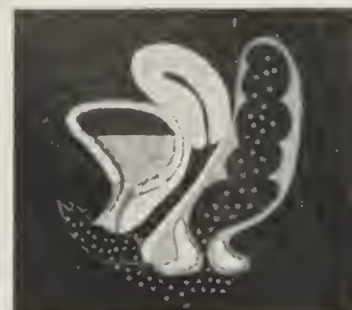
ROCHE

For recurrent attacks of urinary tract infection in women

Bactrim™ DS Double Strength Tablets

Each tablet contains 160 mg trimethoprim and 800 mg sulfamethoxazole.

Just one tablet b.i.d. for 10 to 14 days



- Action at urinary/vaginal/lower bowel sites helps eliminate reservoirs of infecting organisms
- Distinctive antibacterial action plus wide spectrum helps eradicate recurrent UTI
- Low incidence of bacterial resistance in community practice

- Convenient *b.i.d.* dosage provides day-and-night antibacterial control
- Contraindicated during pregnancy and the nursing period. During therapy, maintain adequate fluid intake; perform CBC's and urinalyses with microscopic examination.

Before prescribing, please consult complete product information, a summary of which follows:

Indications and Usage: For the treatment of urinary tract infections due to susceptible strains of the following organisms: *Escherichia coli*, *Klebsiella-Enterobacter*, *Proteus mirabilis*, *Proteus vulgaris*, *Proteus morganii*. It is recommended that initial episodes of uncomplicated urinary tract infections be treated with a single effective antibacterial agent rather than the combination. Note: The increasing frequency of resistant organisms limits the usefulness of all antibacterials, especially in these urinary tract infections.

Also for the treatment of documented *Pneumocystis carinii* pneumonitis. To date, this drug has been tested only in patients 9 months to 16 years of age who were immunosuppressed by cancer therapy.

The recommended quantitative disc susceptibility method (*Federal Register*, 37:20527-20529, 1972) may be used to estimate bacterial susceptibility to Bactrim. A laboratory report of "Susceptible to trimethoprim-sulfamethoxazole" indicates an infection likely to respond to Bactrim therapy. If infection is confined to the urine, "Intermediate susceptibility" also indicates a likely response. "Resistant" indicates that response is unlikely.

Contraindications: Hypersensitivity to trimethoprim or sulfonamides; pregnancy; nursing mothers; infants less than two months of age.

Warnings: Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia with purpura in elderly patients on certain diuretics, primarily thiazides. Sore throat, fever, pallor, purpura or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended; therapy should be discontinued if a significantly reduced count of any formed blood element is noted.

Precautions: Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function.

Adverse Reactions: All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. **Blood dyscrasias:** Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. **Allergic reactions:** Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. **Gastrointestinal reactions:** Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea and pancreatitis. **CNS reactions:** Headache,

peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. **Miscellaneous reactions:** Drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L. E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.

Dosage: Not recommended for infants less than two months of age.

Urinary Tract Infections: Usual adult dosage—1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 10-14 days.

Recommended dosage for children—8 mg/kg trimethoprim and 40 mg/kg sulfamethoxazole per 24 hours, in two divided doses for 10 days. A guide follows:

Children two months of age or older

Weight		Dose—every 12 hours	
lbs	kgs	Teaspoonfuls	Tablets
20	9	1 teasp. (5 ml)	½ tablet
40	18	2 teasp. (10 ml)	1 tablet
60	27	3 teasp. (15 ml)	1½ tablets
80	36	4 teasp. (20 ml)	2 tablets or 1 DS tablet

For patients with renal impairment:

Creatinine Clearance (ml/min)	Recommended Dosage Regimen
Above 30	Usual standard regimen
15-30	½ the usual regimen
Below 15	Use not recommended

***Pneumocystis carinii* pneumonitis:** Recommended dosage: 20 mg/kg trimethoprim and 100 mg/kg sulfamethoxazole per 24 hours in equal doses every 6 hours for 14 days. See complete product information for suggested children's dosage table.

Supplied: Double Strength (DS) tablets, each containing 160 mg trimethoprim and 800 mg sulfamethoxazole, bottles of 100; Tel-E-Dose® packages of 100. Tablets, each containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 40, available singly and in trays of 10. Oral suspension, containing in each teaspoonful (5 ml) the equivalent of 40 mg trimethoprim and 200 mg sulfamethoxazole, fruit-licorice flavored—bottles of 16 oz (1 pint).

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Please see back cover.

Her next attack

the BactrimTM 3-system counterattack



ROCHE

Bactrim has shown high clinical effectiveness in recurrent cystitis as a result of its wide spectrum and distinctive antimicrobial action in the urinary, vaginal and lower intestinal tracts.

The probability of recurrent urinary tract infection appears to be enhanced by the establishment of large numbers of *E. coli* or other urinary pathogens on the vaginal introitus. The trimethoprim component of

Bactrim diffuses into vaginal fluid in effective concentrations, thus combating migration of pathogens into the urethra.

Studies have shown that Bactrim acts against *Enterobacteriaceae* in the bowel without the emergence of resistant organisms. Thus, Bactrim reduces the risk of introital colonization by fecal uropathogens. It has *no* significant effect on other normal, necessary intestinal flora.

Bactrim fights uropathogens in the urinary tract/vaginal tract/lower intestinal tract

Please see reverse side for summary of product information.

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CAPSULES

DEC 11 1980

MEDIGRAM

THE MSMS MASTER PENSION Board of Trustees will meet Dec. 3 to study the preliminary results of an MSMS telephone survey just completed. The pension program trustees, headed by Justin L. Sleight, MD, Lansing, plan to decide then how to proceed with the proposed MSMS program. The telephone survey was made during the past weeks by a Grand Rapids professional research firm which contacted 200 MSMS members selected at random. The survey was to determine how members feel about such a plan and what specific plan would best work.

RECENT REYE'S SYNDROME STUDIES conducted independently by the state health departments of Arizona, Michigan and Ohio, in conjunction with the Center for Disease Control, show an association between the use of aspirin and the occurrence of the disease. While the results are still preliminary, and further studies need to be performed, the MDPH feels the existing evidence should not be ignored, and is advising parents to exercise caution when administering these medicines to children with certain viral illnesses, particularly influenza or chickenpox.

The MDPH continues to urge Michigan physicians to telephone local and state health departments as soon as possible after seeing suspected cases of Reye's Syndrome. Please contact William Hall, MD, or Ronald Waldman, MD, Division of Disease Surveillance, MDPH, 517/373-1369.

\$162 million softens Medicaid cuts only a bit

"Primary care" procedures will be reimbursed at 1977 Medicare screen levels but other physicians will absorb a 10 percent discounting of Medicaid billings under a Department of Social Services budget ground out late Nov. 24 and forwarded for full legislative action. A physician services line item in the austere Medicaid budget totals approximately \$162 million, which would allow physicians 10 percent more dollars than in fiscal 1980; however, the anticipated caseload and utilization increases under the Medicaid program due to Michigan's economic woes forced limitations on reimbursement screens. The 10 percent discount will replace the 15 percent discounting announced earlier by DSS when it was functioning without a budget. The discount will take effect Dec. 15. Legislators expect that exempting primary care from the discount will encourage office care for Medicaid recipients and cut down on more expensive emergency room use. David Siegel, MD, chairman of the Medicaid Liaison Committee, feels that this action was taken without consideration of the fact that this fee level represents a 41 percent discount of fees promised by the legislature. His complete reaction will be published in the January issue of Michigan Medicine.

MSMS Annual Scientific Meeting draws responses of "excellent!"

"Excellent speakers." "Very good course." Those were the evaluations heard most often from the 1,600 Michigan physicians who attended the 1980 MSMS Annual Scientific Meeting Nov. 18-19-20 at the Hyatt Regency Dearborn. Approximately 1,600 physicians attended the 54 Category I courses offered, which included a two-day Advanced Cardiac Life Support program. Praises now are going to Samuel M. McMahon, MD, Lansing, Annual Scientific Meeting Chairman; to members of Doctor McMahon's advisory committee; to Carl F. Hammerstrom, MD, Marquette, chairman, MSMS Committee on Continuing Medical Education Programming, and to the MSMS staff.

THE MICHIGAN BOARD OF Medicine plans two public hearings Dec. 5 in Conference Room A, 905 Southland, Lansing. Subjects and times of the hearings are: general rules on amphetamines, 1 p.m., and general rules on levying of fines, 2 p.m. Comments may be presented orally, with written copies available to the board, or submitted by mail through Dec. 10.

A copy of the proposed rules may be obtained from the board office, 905 Southland, Box 30018, Lansing, 48909, or at the public hearing.

ASSESSING THE 1980 general elections and Michigan Doctors Political Action Committee candidate support, MDPAC Chairman Thomas C. Payne, MD, Lansing, says: "Michigan democrats probably are rationalizing the results by saying there was a tremendous national resurgence of Republicanism and conservatism, but it didn't spill over so much in Michigan. That's probably true, as they (Democrats) still have a commanding lead in our statehouse, where the Republicans picked up a net of 6 seats but still are outnumbered 64 to 46. Even so, I believe our Democratic state legislators will be a little leary of proposals calling for large state expenditures."

Conference committee finishing work on Blue Cross/Blue Shield reform bill

The House/Senate Conference Committee, struggling with Blue Cross Blue Shield reform legislation (HB 4555), has come close enough to agreement to order reprinting of the bill. Only one or two items remain to be settled. The committee is striving for action before the legislature adjourns sine die in late December. MSMS concerns have been resolved: Per case participation is permitted under the new legislation, direct reimbursement for psychologists is set aside pending discussions between BCBSM and the psychologist profession, consultation and negotiation between BCBSM and provider groups such as MSMS are called for, and the cost containment formulary developed by the "Shelton coalition" is reaffirmed. The next meeting of the conference will be called when the reprinting is complete....Other legislation still to be acted upon this month and of physician interest includes HB 5401, to establish the job classification of medical examiner investigator; HB 6040, to coordinate licensure of drug control licenses with re-registration of medical practice licenses, and remove some restrictions on dispensing physicians; and SB 376, which would repeal legislation requiring motorcycle riders to wear protective helmets.

New MSMS slide-tape show describes health planning

The MSMS Physician/HSA Support Center has a new 13-minute slide/tape show designed to explain the health planning process and to answer the most common questions raised by physicians. The presentation is available for county medical society, auxiliary and hospital staff meetings. The slide/tape show can be presented independently or as a 'trigger' film to initiate discussion conducted by a physician or MSMS staff member. To reserve this presentation for your meeting, please contact Dennis Paradis, MSMS Physician/HSA Support Center, 120 W. Saginaw, East Lansing, 517/337-1351.

Michigan State Medical Society
120 West Saginaw Street
East Lansing, Michigan 48823

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Editor: Judith Marr

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CAPSULES

JAN 6 1981

THE FEDERAL TRADE COMMISSION'S lawsuit against MSMS over alleged illegal coercion of Blue Cross Blue Shield of Michigan probably will conclude in March or April, MSMS Legal Counsel A. Stewart Kerr reported to the MSMS Council Dec. 3. The judge's decision is expected then. The FTC offered rebuttal testimony in November.

As we go to press, MSMS is considering whether to petition for the right to present counter-rebuttal testimony: this may be unnecessary as the trial "record" is even better than Mr. Kerr and Mr. Sankbeil anticipated. In any event, the trial record will be closed in January and thereafter there will be no testimony.

The lawsuit could be a landmark case in health care law. If MSMS loses, it could lead to a ban on all discussion of payment policy in Michigan professional trade publications and meetings.

THE MICHIGAN DOCTORS Political Action Committee (MDPAC), is seeking Michigan physicians' membership contributions. Looking toward 1982 after this year's flurry of election year campaign contributions, MDPAC is seeking \$150 sustaining memberships and \$50 regular memberships. In 1982, MDPAC must be ready for Michigan voters to elect a governor, one U.S. senator, 38 state senators and 110 state representatives. MSMS members may join MDPAC when they remit their MSMS membership dues.

HB 4555 on governor's desk; it's a bill of compromises

The Michigan House and Senate have passed the legislative conference committee's compromise Blue Cross Blue Shield of Michigan reform bill (HB 4555). The bill is on the governor's desk for signing. MSMS State Legislation and Regulations Committee Chairman W. E. Maldonado, MD, predicted the bill's enactment Dec. 3 when he reported to the MSMS Council.

"I wish I could tell you it is perfect," Doctor Maldonado said, "but the best way I can describe the bill is that it is 109 pages of compromise." The bill meets most of the goals set by the MSMS Council in its directives to Doctor Maldonado's committee a year ago. According to the bill, the BCBSM board will have 35 members, three of them physicians (at least two will be MDs), provides inflation and growth factors for reimbursement, and requires BCBSM to consult with MSMS when developing its cost control programs. Per-case participation options will be continued. "BCBSM will be more regulated, and its subscribers will have more say," summarized Doctor Maldonado.

Doctor Reizen resigns, wants to stay in government

Maurice S. Reizen, MD, director, Michigan Department of Public Health, declared he would like to stay in state government as he talked with the MSMS Council about his resignation from his post effective Jan. 3.

"My reasons for leaving are not simple," said Doctor Reizen. They include, he said:

- 1) Budgetary processes "which are an absolute nightmare this year." His department has been ordered to make at least six budget cuts this year. "We're just consumed with budget programs," he said, "and the legislature won't decide which programs go or which stay and will be funded."
- 2) Current legislative processes which call for programs but don't provide funds, and
- 3) Differences in salary between his position as an appointed state official and that of his top bureau chief, a civil servant who earns \$27,000 more per year than Doctor Reizen does.

Doctor Reizen is very concerned, he said, that MSMS works to ensure his replacement is an MD.

A RECENT FAMILY WEEKLY (Sunday supplement) poll on "timely issues" found that 68 percent of respondents said no to the question, "Should the U.S. Government make available more health services, which ultimately would be paid for through taxes?" Twenty-four percent said yes, and eight percent were unsure.

THE MSMS PHYSICIAN SERVICE GROUP, Inc. continues to conduct practice management consultations. During the past 18 months they have consulted with physicians in a variety of fields. All physicians consulted with have been pleased with the resulting efficiency and effectiveness of their office operations.

A practice management consultation covers a variety of office operations such as accounting, office set-up, filing systems, scheduling, work flow, patient flow and personnel. If you should need advice in these areas and others, contact John Anthony at (517) 337-1351.

ANY PHYSICIAN, hospital or community committee interested in recruiting physicians can register needs with the Physician Placement Service of the Michigan Health Council, 1407 S. Harrison Road, East Lansing, 48823. The Council lists 506 physicians interested in possible Michigan practice opportunities. The MHC executive vice president is Herbert A. Auer.

MSMS Council highlights

At its regular Dec. 3 meeting, The MSMS Council:

- 1) Approved a five-part program for recruiting new MSMS members in 1981. The program calls for minimum goals of 300 new dues-paying members, 150 new Michigan AMA members, 300 resident members and 100 student members. The program will provide membership recruitment workshops, direct mailings, specific staff support, and educational seminars for foreign medical graduates and their families.
- 2) Authorized MSMS staff participation with the Michigan Hospital Association to study the efficacy of PSROs and of PL 93-641, the federal health planning law. The Council also established a new liaison committee with the Michigan Hospital Association.
- 3) Concurred with presidents of Michigan specialty societies in their wish to discontinue the Michigan Council of Specialty Societies and called for an ad hoc MSMS committee to suggest ways for better communications with specialty societies.
- 4) Approved appointment of a task force to design and recommend formal mechanisms for effective communication and working relationship of MSMS with medical staffs of Michigan hospitals.
- 5) Approved an MSMS initiative to foster and help establish a Michigan health care economic coalition with formal proposals to be presented to the Council in January.
- 6) Endorsed and offered MSMS assistance for implementation of a Michigan version of the AMA's Uniform Claim Form 1500, urging that all concerned groups implement the form at the same time.
- 7) Approved sending a letter to the governor and to the Office of Health and Medical Affairs supporting the need for a study of long-term care needs in Michigan. Another letter will go to the director, Michigan Department of Public Health, urging that areas where there is a shortage of long-term care beds be authorized to use acute care beds until this long-term care study can be completed. The MSMS Steering Committee on Health Planning is assigned to investigate with the Michigan Hospital Association alternatives to regulatory formulae currently in use for determination of the long-term care needs of Michigan communities.
- 8) Recommended master medical coverage be added to the MSMS group 94000 insurance plan.
- 9) Approved MSMS language drafted by the MSMS Task Force on Certificate of Need Rule 106 as amended, to clearly exempt private physicians' offices from CON

requirements. If this language is not acceptable to the Michigan Department of Public Health, the MSMS Committee on State Legislation and Regulations is authorized to negotiate other proposed language.

10) Voted not to support at this time the Board of Medicine's draft rules for levying fines against physicians who transgress standards of professional conduct.

11) Dissolved the MSMS Liaison Committee with the Board of Medicine and assigned its responsibilities to the MSMS Committee on State Legislation and Regulations, to better achieve unity of purpose between MSMS and the board.

12) Established an ad hoc committee to offer the selection committee suggestions for successors to Maurice S. Reizen, MD, whose resignation as director of the Michigan Department of Public Health will be effective Jan. 3. The Council also adopted a position supporting Doctor Reizen's views that his replacement should be an MD.

AMA delegation presenting Michigan resolutions

The MSMS Delegation to the AMA took three resolutions to the AMA House of Delegates' Interim meeting Dec. 7-10 in San Francisco. The delegates, led by Chairman Richard J. McMurray, MD, Flint, are asking the AMA House:

1) to accelerate its efforts to repeal PL 93-641, the national health planning act, and to design a program of voluntary, locally-based health planning to address local needs with local resources, as an alternative;

2) to pool efforts with state medical societies to keep all physicians informed of their legal responsibilities and to codify state and federal laws that directly affect the physician and his or her relationships with patients;

3) to reaffirm its leadership role in correctional health care by clarifying its intent to house the Department of Correctional Activities at the AMA's headquarters in Chicago; immediately develop a meaningful strategy to fund its current efforts in correctional health care through a combination of private, state and federal funds, and strongly support the need for further research and development of alternative models of health care delivery in correctional institutions.

CAPSULES/continued

FORMS FOR MICHIGAN'S medical arbitration system are available from MSMS at cost. Agreement forms and booklets for 100 patients are \$10.50. (Other quantities available.) Contact Mrs. Nancy Wimmer, MSMS headquarters, 517/337-1351.

THE MICHIGAN DEPARTMENT of Public Health requests physicians report suspected Reye's Syndrome cases as soon as seen to MDPH, Division of Disease Surveillance (517/373-1396) and local communicable disease units.

THE AMERICAN COLLEGE of Obstetricians and Gynecologists has called for women to stop using super-absorbent tampons until toxic shock syndrome has been more thoroughly studied. The recommendation resulted from an examination of the tampon and toxic shock syndrome by the college's Committee on Gynecologic Practice and its staff physicians. To reduce the risk of tampon use even further, women are advised to alternate tampons with sanitary napkins or minipads during the menstrual cycle, and to change tampons frequently.

"A PASSING FANCY" is all new political opportunities following the national elections will amount to if physicians fail to follow through with responsible participation and involvement. That's the challenge leveled by MSMS President John R. Ylvisaker, MD, in his president's page article in the December issue of Michigan Medicine. Doctor Ylvisaker outlines four steps he feels physicians must follow to take up this challenge. "We physicians must accept our individual and collective responsibility as part of the new mandate we have helped to effect," he says.

PHYSICIANS AND NURSES should mark their calendars today for the 1981 Michigan Conference on Maternal and Perinatal Health. The dates are March 25 and 26 and the place is the Hyatt Regency Dearborn. MSMS again is the major sponsor, with several statewide specialty societies and interested health organizations supporting the conference. Topics will include resuscitation, management of premature labor, congenital abnormalities and NICU burnout. Look for registration forms and information re: speakers in coming issues of Medigram and Michigan Medicine. Details are available from Katie Brewbaker at MSMS headquarters, 517/337-1351.

A NEW CERTIFICATE of immunization is being distributed by local public health departments. The new certificate has been developed by the Michigan Department of Public Health and primarily is intended for parents of newborns. The MDPH expects the form to become a required document for admission to public and private schools throughout the state.

Medicaid line items for MDs shrinking in actual dollars

If anybody can afford a cut in reimbursement, it's physicians. That is the legislature's philosophy when it comes to the Medicaid budget appropriations, outgoing Medicaid Liaison Committee Chairman David Siegel MD, Lansing, told the MSMS Council Dec. 3. The legislature has seemingly improved things for physicians by giving them a 10 percent rather than 15 percent discounting as originally proposed in Medicaid reimbursements. But the legislature has reduced the pot from which the reimbursements will be made. So the physician line item now is less than last reported.

Doctor Siegel resigns

David Siegel, MD, Lansing, dynamic chairman of the MSM Medicaid Liaison Committee for six years, submitted his resignation to the MSMS Council Dec. 3. Doctor Siegel, whose leadership with state and legislative officials helped make the Michigan Medicaid program an acknowledged national leader, will provide a full statement on his resignation in Michigan Medicine.

Medicaid fraud bill passes

A Medicaid fraud and abuse bill, HB 5868, has been approved by both houses and is on the Governor's desk for signing. The bill gives the Michigan Department of Social Services director statutory authority to enforce policy discouraging fraud and abuse in the Medicaid program. MSMS has played an active role in support of the legislation. Gerald Mandell, MD, Detroit, chairman, MSMS Task Force on Medical Fraud and Abuse, testified twice before the Senate Committee on Health and Social Services seeking an increased role for peer review. The bill was amended to require that the peer review system be the basis for all MDSS determinations of medical necessity and appropriateness.

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MICHIGAN MEDICINE

December 1980

JOURNAL OF THE MICHIGAN STATE MEDICAL SOCIETY

Vol 79, No 35



**Physicians and nurses,
mark your calendars!**



**1981 Michigan Conference
on Maternal
and Perinatal Health**

March 25

- Management of Premature Labor
- Diagnosis and Management of Intrauterine Growth Retardation: The Mother/The Newborn
- The Resuscitation Team: How to Build the Best
- When and When Not to Resuscitate
- Resuscitation: Its Ethical Considerations
- Resuscitation: What are the Legal Implications

March 26

- How Bad is Bad: What are the Degrees of Abnormality?
- Why Did It Happen to Our Baby?
- After the Neonatal ICU:
To the Nursery/Into the Community
- Burnout: How Do You Avoid It?

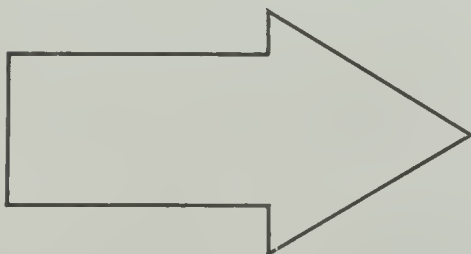
**March 25-26, 1981
Hyatt Regency Dearborn**

Michigan State Medical Society Membership Benefits

Are you aware of the services available to you as an MSMS member?

On the following two pages is a summary of the member benefits, including all insurance coverages, which are available through the Michigan State Medical Society. All members are encouraged to review this information to be fully aware of all the benefits available and to determine if and where these coverages may fill a void or supplement your existing insurance program.

Any questions or comments regarding these programs may be directed to Wayne Burmeister, manager, Department of Operations and Member Services, Michigan State Medical Society Headquarters, 120 W. Saginaw, East Lansing, 48823 (Telephone — 517/337-1351).



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Member benefits available for Michigan State Medical Society members

Insurance programs					Other programs
Type	Coverage Available	Special Features	Administrators	Eligibility/How to Apply	
1. Disability Income Protection Accident & Sickness	Optional amounts up to \$1,500 monthly benefit. Benefits paid from the 1st & 16th day, 30th day, or 90th day of disability, and, benefit duration is lifetime for accident and up to age 65 for sickness, depending on the plans selected. Coverage automatically includes waiver of premium, accidental death & dismemberment coverage, up to 7 days indemnity for non-disabling injuries, & partial disability payments. The plan is underwritten by Provident Life & Accident Insurance Company, Chattanooga, Tennessee.	New members guaranteed \$500 monthly benefit, regardless of medical history. Indemnity paid for first 15 days of hospital confinement for sickness. Guaranteed conversion if member leaves the state to continue full time practice in another state. Claims not pro-rated because of benefits received from other insurance.	Stratton-Cheeseman & Associates, Inc. 1305 Abbott Road, P.O. Box 1563 East Lansing, Michigan 48823	All MSMS members, under age 75, residing in Michigan, practicing full-time, may apply. Apply to the administrator, Stratton-Cheeseman & Associates, Inc. Call 1-517-351-5780 for applications & information, or Toll Free, (Michigan) 1-800-292-1966.	<i>Michigan Medicine and Medigram</i> Representation in Lansing and Washington. Legislative reports. MSMS Annual Scientific Meeting. Michigan Conference on Maternal and Perinatal Health. Michigan Conference on Sports Medicine. Staff support on government agencies. Malpractice claims analysis. Travel programs. Directory of members. Auto leasing/rental programs. Membership statistics. Impaired physicians program Health systems agencies support center Physician Legislative Network PSRO liaison
2. Business Overhead Disability Coverage	Optional amounts up to \$3,000 monthly benefit. Reimbursement for office expenses; i.e., rent, employees' salaries, utilities, malpractice insurance premiums, etc., during a period of total disability. Benefits payable from the 16th day of disability. Benefits are payable until the Maximum Overhead Expense Benefit Limit is reached — which is the monthly benefit times twenty-four. Waiver of premium is automatically included. The plan is underwritten by Provident Life & Accident Insurance Company, Chattanooga, Tennessee.	Premiums constitute a business expense and are deductible from gross income before taxes (IRS, 55-264, I.R.B. 1955-19, p. 8).	Stratton-Cheeseman & Associates, Inc. 1305 Abbott Road, P.O. Box 1563 East Lansing, Michigan 48823	All MSMS members residing in Michigan who practice full-time are eligible to apply. Apply to the administrator, Stratton-Cheeseman & Associates, Inc. Call 1-517-351-5780 for applications & information, or Toll Free, (Michigan) 1-800-292-1966.	
3. Term Life Insurance	Available in amounts of \$25,000, \$50,000, \$75,000 or \$100,000. Renewable to age 70 (amount reduced at age 65). Waiver of premium is included. Full conversion available to the Permanent Life Insurance Plan after policy is in force one year. This plan is underwritten by The Mutual Benefit Life Insurance Company, Newark, New Jersey.	New MSMS members guaranteed \$25,000, regardless of medical history. Participating members are eligible to share any dividends that become payable. Guaranteed conversions to ordinary life if membership is discontinued. Conversions also available to Permanent Life at age 65 reduction and age 70 termination.	Stratton-Cheeseman & Associates, Inc. 1305 Abbott Road, P.O. Box 1563 East Lansing, Michigan 48823	All members, under age 70, active full time in a professional position, are eligible to apply. Apply to the administrator, Stratton-Cheeseman & Associates, Inc. Call 1-517-351-5780 for applications & information, or Toll Free (Michigan) 1-800-292-1966.	
4. Special Accidental Death & Dismemberment Benefits	Provides benefits for loss of life, limbs, or sight as the result of an accident in amounts of \$25,000, \$50,000, \$75,000, or \$100,000. Coverage for the spouse may be purchased — the amount will be 50% of the member's principal sum. This plan is underwritten by Provident Life & Accident Insurance Company, Chattanooga, Tennessee.	Around-the-clock protection and world-wide coverage. Sports and recreation as well as professional duties are fully covered. Renewable to age 70.	Stratton-Cheeseman & Associates, Inc. 1305 Abbott Road, P.O. Box 1563 East Lansing, Michigan 48823	All MSMS members, under age 70, engaged full time in their profession in the State of Michigan are eligible to apply. Apply to the administrator, Stratton-Cheeseman & Associates, Inc. Call 1-517-351-5780 for applications & information, or Toll Free (Michigan), 1-800-292-1966.	MSMS Physicians Service Group, Inc. Practice management seminars Account executives Credit card payment system IC collection service Office management consultations Specialty Society administrative services
5. Disability Income Protection For Employees of Members	Available in various amounts up to \$500 monthly benefit. Choice of 7-day, 15-day, or 30-day waiting period for benefits to begin. Two benefit durations available: one-year accident/one-year sickness; and, five-years accident/two-years sickness. Waiver of premium included. This plan is underwritten by Provident Life & Accident Insurance Company, Chattanooga, Tennessee.	Premium is a tax deductible expense when paid by the employer.	Stratton-Cheeseman & Associates, Inc. 1305 Abbott Road, P.O. Box 1563 East Lansing, Michigan 48823	Employees, under age 60, who are employed full time by an MSMS member. Apply to the administrator, Stratton-Cheeseman & Associates, Inc. Call 1-517-351-5780 for applications & information, or Toll Free (Michigan), 1-800-292-1966.	
6. Professional Liability Insurance	Limits of \$100,000/\$300,000, \$200,000/\$600,000; \$1,000,000/\$1,000,000 available in occurrence policy forms. This plan is underwritten by Michigan Physicians Mutual Liability Company, East Lansing, Michigan — a physician-owned company.	A 50% premium discount to first-year practitioners, part-time or semi-retired physicians. No charge for P.C./partnership coverage. Premium financing available.	Stratton-Cheeseman Management Company, Inc. 1305 Abbott Road, P.O. Box 1563 East Lansing, Michigan 48823	Write or call Michigan Physicians Mutual Liability Company for a free introductory kit. Telephone numbers are: East Lansing (517) 351-1150; Birmingham (313) 647-5550, or, toll free (800) 292-1926.	
7. MEDGARD Property & Liability Insurance	Comprehensive property & liability insurance for physicians' offices and other property. Selection of optional coverages. This plan is underwritten by Michigan Physicians Mutual Liability Company, East Lansing, Michigan.	Broadest all-risk replacement cost coverage. Insurance designed specifically for physicians. Competitively priced. Advantage of one company — total coverage.	Michigan Physicians Mutual Liability Company 1305 Abbott Road, P.O. Box 1471 East Lansing, Michigan 48823	For more information, call 1-517-351-1150, or toll free, 1-800-292-1926, to talk with one of the representatives. All Michigan physicians are eligible to apply.	
8. Hospital/Medical	Four option coverages available to physicians and their families. Excellent benefits to cover both hospital and medical services. Separate benefit program available for employees.	Option I: 365 day comprehensive hospital, 365 day Blue Shield UCR, 45 day nervous, mental and TB. Option II, 365 day comprehensive hospital, no Blue Shield benefits. Option III, same as Option I except you pay 30% of Blue Cross charges up to \$600, program pays 70% of Blue Shield charges and you pay 30% UCR. Option IV, same as Option II except you pay 30% of Blue Cross charges up to \$600 and no Blue Shield benefits.	Blue Cross and Blue Shield of Michigan 600 Lafayette East Dept. J401 Detroit, Michigan 48226	Available to all MSMS members and their employees. Application form is available from MSMS Department of Member Services, 120 W. Saginaw St., East Lansing, 48823. (Tel. 517/337-1351)	

1953.

- General Dwight D. Eisenhower was inaugurated President of the United States; his vice president was Richard M. Nixon.
- The Korean armistice was signed to end the Korean War.
- Not one home owned an electronic calculator or color TV.
- It cost 3¢ to mail a letter.
- The Studebaker was the "new American car with the European look."
- Jacqueline Bouvier was engaged to U.S. Senator John F. Kennedy; and
- the Stratton Agency began serving the Michigan State Medical Society!

We have appreciated your participation and support over the past 27 years. If you would like additional information about our services, we would be happy to hear from you.

STRATTON-CHEESEMAN & ASSOCIATES, INC.

1305 Abbott Road, P.O. Box 1563
East Lansing, Michigan 48823



800-292-1966

MISMS at work---

**---serving doctors,
public in
many ways**

THE COUNCIL MICHIGAN STATE MEDICAL SOCIETY 1980-81

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MSMS is . . .

. . . An active, growing entity of more than 9,600 members dedicated to the practice of quality medicine and the highest ideals of patient care.

. . . An association of the medical doctors of Michigan, open to any licensed MD or DO who voluntarily agrees to abide by the constitution and bylaws of the organization.

. . . An organization which helps to protect and promote the private, independent practice of medicine, and helps to insure that physicians' voices are heard on matters of professional concern.

. . . A voluntary organization dedicated to the continuing medical education and professional improvement of its membership so that the people of Michigan can enjoy the best possible health care.

. . . A group of physicians dedicated to cost effective medical care rendered with care, quality and humanity.

Membership in MSMS Means . . .

. . . Accessibility to a wide range of benefits and services including: insurance programs, continuing medical education programs; travel packages for you and your family; car lease plans; management and consulting services; and publications which keep you informed of political and socio-economics developments affecting the practice of medicine.

In addition to these tangible benefits, MSMS serves as medicine's voice in Michigan to the public, the legislature, health planning groups and the government's executive departments.

At a time when medicine is faced with unprecedented challenges from virtually every front, the scope of MSMS activities continues to expand. The society is involved in nearly every area affecting physicians, from legislation and health planning to CME and monitoring health maintenance organization developments.

We want to introduce you to the services and benefits offered by MSMS to its members.

MSMS at work---

**... studying, influencing
medical care legislation**

Government relations at MSMS is your voice in the state capitol. Day-to-day the staff evaluates and suggests state legislation, and protects the professional imperatives of the medical profession. The Society conducts a highly-effective legislative program to protect physicians' rights and pass legislation beneficial to patients. The importance of this activity is obvious, since approximately one of every five bills introduced deals with medicine or health.

The Department of Government Relations serves MSMS members by monitoring, interpreting, and influencing the actions of the State and Federal government in relation to the medical profession and health care delivery. Through its liaison with the Legislature and MSMS members, the medical profession's viewpoint is represented. The department also recommends policies, and actions for formulating activities and strategies for physician-selected programs.

The Department of Government Relations maintains relationships with the Board of Medicine and the Health Occupations Council. It also coordinates efforts relating to state government, the State Health Department and various other groups.

The Physician Legislative Network, (formerly the "Doctor-of-the-Week" program) uses individual physicians in lobbying efforts. Frequent medical society meetings with legislators provide continuing contact between elected officials and local physicians. The Physician Legislative Network is designed not only to keep physicians involved in legislative activities, but to demonstrate to legislators that the medical society and physicians are concerned with many issues, not just those related to medicine.

MSMS Physician/Health Systems Agencies (HSA) Support Center assists in the effective planning of health care delivery systems. The Support Center works with physician advisory committees in the regional health service areas, and provides current information about health planning issues.

In addition, the Support Center is charged with developing educational materials, slide/tape presentations, seminars, etc., to better prepare physicians to take an active role in health planning. The Physician/HSA Support Center has produced a briefing manual for physicians in the health planning area, a pamphlet to raise physician awareness of HSAs and a monthly UPDATE column in *Michigan Medicine*.

The *Washington Visitation* allows Michigan doctors to exchange ideas with Michigan members of Congress. A delegation of MSMS members travels to Washington, D.C. to share physicians' concerns about health care. *Washington Visitation* keeps doctors involved with the Congressional delegation, not as lobbyists, but to represent members and demonstrate concern for what medicine represents.

The Michigan Doctors Political Action Committee functions separately from MSMS, as a voluntary non-profit group of physicians, spouses and other interested persons. It directly affects the makeup of the legislature by supporting political candidates sensitive to the needs of organized medicine. MDPAC works to keep doctors informed of medical-political issues and gives them an avenue for concerted political action. MDPAC informs members regarding candidates who support or do not support medicine's position. It coordinates its efforts with other groups working for better government. The Michigan Doctors Political Action Committee represents the philosophy of the profession and is guided by a 30-member MD board of directors.

MSMS at work---

**. . . communicating with
public and profession**

MSMS utilizes various media to improve public understanding of the medical profession in Michigan. MSMS stays in continual contact with key media personnel throughout Michigan and is always ready to help them obtain medical information and stories. Through news releases, news conferences, public service announcements and providing medical speakers for talk shows, interviews and other occasions, MSMS keeps medicine before the public in a favorable light. In an average year, MSMS responds to more than 700 inquiries from the public and media.

The public relations program recently approved by the MSMS House of Delegates will seek to tell medicine's story, concerns and feelings directly to the Michigan public through various programs and media.

MSMS serves as a communications consultant to component societies and specialty societies who undertake particular programs.

Utilizing recently acquired television equipment, MSMS offers training programs for physician spokespersons, component officers and others who represent the profession before the media and public.

Michigan Medicine, the monthly MSMS magazine, provides useful information to Michigan physicians about MSMS and contemporary issues, with special articles highlighting socio-economics, legislation and news about medicine in Michigan. Major medical developments are also reported and interpreted, along with office management tips, vital statistics, a comprehensive guide of continuing medical education programs offered throughout the state, and a lively letters column.

Medigram, a biweekly newsletter, communicates condensed information on fast-breaking medical news. It ensures that members are well informed about governmental actions and other activities which affect their practices.

MSMS at work---

**. . . offering
quality CME programming**

A major function of MSMS is to provide high quality continuing medical education programs. These enable physicians to stay abreast of medical advances and obtain necessary credit hours to renew their medical licenses.

At the Annual Scientific Meeting each fall, doctors may obtain up to 18 hours of Category I credits by attending several of the 50 or more courses offered during the three day meeting. The courses feature outstanding speakers and medical educators from Michigan, the United States and often foreign countries. They cover nearly every medical specialty.

Each spring the MSMS Committee on Maternal and Perinatal Health plans a two-day conference which offers doctors, nurses and other interested professionals the latest information and advances in this specialized field of medicine.

And for the sports-minded physician, MSMS annually sponsors a spring conference on Sports Medicine. Team physicians, coaches and athletic directors from across the state come to the one-day event to learn the current state-of-the-art in treating and prevention of athletic injuries.

In these three events a physician could earn up to 35 hours of Category I credit towards his/her relicensure, at a cost substantially below what might be paid for similar credits elsewhere.

MSMS at work---

... accrediting CME activities

Separate from its CME programming efforts, MSMS is responsible for granting accreditation approval to hospitals, institutions and groups seeking to offer Category I continuing medical education programs. The MSMS Committee on CME Accreditation requires any group seeking accreditation to meet numerous high educational criteria before the coveted status is granted. MSMS believes the stringent standards guarantee top quality education efforts which give members the latest and best in medical knowledge.

MSMS at work---

... offering a host of member benefits

Insurance Programs

Membership in MSMS provides real dollar savings and vital protection through group insurance opportunities. These services are coordinated by the MSMS Department of Operations and Member Services.

Six group insurance plans are available to MSMS members:

1. Professional office overhead coverage.
 2. Michigan Blue Cross Blue Shield for hospital and medical-surgical care for physicians, their families and their employees.
 3. A disability-sickness policy for employees.
 4. Group life, both permanent and term.
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5. Accidental death and dismemberment.
 6. Disability income.

More than 50% of MSMS members are enrolled in at least one of the plans, at a group rate which offers considerable savings. The Society mails to each new member a series of descriptive brochures concerning group plans available.

In order to participate, a doctor must first be a component society member and then an MSMS member. Interns and residents enrolled as associate members in MSMS also are eligible for several selected policies.

Travel Programs

MSMS in cooperation with *Intrav*, each year offers several travel programs of varying length and location. The tours offer substantial savings over individual travel while permitting the maximum in unregimented time for the traveler to make personal choices of sightseeing, shopping and entertainment opportunities. Brochures about these travel programs are periodically mailed to all MSMS members.

Car Lease & Car Rental Programs

MSMS offers members programs for leasing automobiles or other vehicles through a large leasing agency at competitive prices. A brochure is available describing full details of the leasing plans.

Members who need to rent cars can enjoy considerable discounts both at home and abroad by utilizing the options offered to MSMS members by one of the world's leading rent-a-car companies. Savings of 20-30% are immediately available to members displaying the special credit card sticker mailed to new members.

Professional Liability Insurance

Physicians desiring professional liability insurance can obtain it through the Michigan Physicians Mutual Liability Company, Inc., an independent insurance company created by and through the efforts of MSMS. While the company is a legally separate corporation with its own board of directors and staff, the MPMLC and MSMS continue to work together closely to offer competitive insurance programs and on-going educational efforts in risk-management aimed at lessening a physician's professional liability exposure. MPMLC has the endorsement of MSMS and is looked on as a company of doctors, run by doctors for doctors.

MSMS

at work---

**... compiling
economic data for physicians**

MSMS focuses on the total health care delivery system through the Bureau of Economics. The Bureau analyzes various ways physicians organize, deliver and finance medical care. Special consideration is given to the various forms of pre-payment systems, including HMO/IPAs, as well as third party payment systems. Another activity of the Bureau is to understand and prevent medical malpractice through analyzing professional liability insurance claims.

MSMS

at work---

**... improving
health care in jails**

Through its leadership in the national Law Enforcement Assistance Administration Association/AMA project, MSMS is actively working with 15 out of 30 jails in Michigan to improve health care for county jail inmates. The MSMS goal is to assist the jails in maintaining their AMA accredited health programs or in meeting the standards necessary to obtain accreditation. The MSMS program is designed to improve the jail's health care delivery system from the time the inmate enters the facility until he/she is transferred or released. Through MSMS, which was one of the first six state societies to take part in this major project, a wide range of technical assistance services is available to participating jails.

MSMS at work---

**. . . caring
for impaired colleagues**

In recognition of the problems faced by the physician afflicted with alcoholism, drug abuse or other physical or mental impairment, MSMS has an active Impaired Physician Program. The MSMS committee offers confidential intervention services to deal with impaired physicians. The major thrust of the current work is to promote programs on the local component level. MSMS has developed educational, promotional and training programs for interested physicians to properly prepare them to deal with impairment problems they encounter.

Additionally, MSMS has established a Physician's Loan Fund to assist needy physicians during their rehabilitation.

MSMS at work---

**. . . dealing with
the ethics of medicine**

The MSMS Judicial Commission is charged with interpreting the Constitution and Bylaws of MSMS and of component societies with regard to professional ethics, mediation, grievances and discipline. It has the authority to make ethical interpretations and decisions in such matters for all members of MSMS. Questions of ethics originate on the local level and may be resolved there. Matters

not settled on the local level can be referred to the Judicial Commission which meets at least three times per year. The Commission is composed of ten members from seven Judicial districts who are elected by mail ballot of active members in their respective districts.

MSMS

at work---

**. . . serving you,
the doctor**

Physician Service Group, Inc.

The Physician Service Group, Inc. is a member service subsidiary of the Michigan State Medical Society. It was created to provide quality services and products to the members of the Michigan State Medical Society. The Physician Service Group is divided into two divisions. One division is the Administrative Services arm which provides secretarial, bookkeeping and membership services to many of the specialty societies. Account executives are assigned to each one of the specialty societies served. These individuals work very closely with the officers and directors of the specialty organizations.

The other division of the Physician Service Group is concerned with more direct services to MSMS members such as practice management consultation. The PSG advises physicians with business problems in personnel, medical records, work flow, patient flow, computer processing and most importantly, billing and collection. The emphasis is to maximize practice income while lowering practice costs.

The PSG endorses and recommends the I. C. System Collection Service Company for physician collections. I. C. System has been in business for over 40 years and has an outstanding reputation for its professional conduct and its success. Over

1,000 MSMS members are currently making use of the I. C. Collection System.

The Physician Service Group offers physician members the use of a credit card program for patients' payments in the doctor's office. The patients may use either Visa or Master Card to pay for services. The rate charged physicians for using this service is 2½%, dramatically below what the physician would have to pay a bank for this service.

The Physician Service Group has specialized consultants on its staff who are available to set up a consultation at the physician's convenience. In addition to their expertise the management of the Physician Service Group has available to it many outside consultants who are available on an ad hoc basis.

MSMS at work---

. . . developing policies on medicine and health

The procedure by which every MSMS member can participate in MSMS policy decisions has been refined over 114 years. Each MSMS member has a voice in establishing the policies of the State Medical Society, through the democratic process set up by the Society. It works like this:

1. Each MSMS member elects delegates to the MSMS House of Delegates. Each member may ask the delegates to introduce resolutions before the House.
 2. Delegates are elected by the 57 component county medical societies. Specialty societies and American Medical Student Association chapters also are represented.
 3. Resolutions are submitted in writing to the House. Each is turned over to an appropriate reference committee, which holds
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open hearings at which an interested MSMS member may testify. Some resolutions are concentrated within the profession, but many concern both doctors and public.

4. After the hearings, the reference committees recommend approval or disapproval, or develop amendments to the resolutions. Their reports then go to the House for action.
5. The members of the House act on the reports of the reference committees. Many points of view are presented. Sometimes a special committee is established to study the matter further and report alternatives to the next session.
6. The MSMS Council, which serves as a board of directors and meets regularly between annual sessions, is responsible for implementation of resolutions.
7. Each adopted resolution is assigned to the appropriate MSMS committees and staff for implementation.

MSMS at work---

**... with you,
the physician**

A Word About Organized Medicine

There are a lot of people coming between you and your patient. Your right to practice is being interrupted by government and others. Many doctors, like yourself, are disturbed by the increasing efforts of government to regulate the ethical system of organized medicine. This seems to contradict the continuing demand by the public sector that medicine take care of its own offenders against medical ethics. In addition, the continuing climate of litiga-

tion and governmental regulations makes it more difficult to take direct and immediate action against those offenders.

Serious (and often successful) attempts are being made each day to take basic decisions away from you and put them in the hands of a bureaucracy already overloaded with red tape and inefficiency. Soon, you may not have the choice to make basic medical decisions such as where you will practice, how much payment you will receive or which drug to give a patient.

How can you, the physician, educate your patients on each of these issues? You can't. Not alone, that is. You can combat some of these outside pressures by educating your patients on the issues right in your office. But it takes time to educate each patient on each of the issues. Time that you may not have. That is why it helps to work collectively, through the organized, aggressive efforts of physicians like you, who are members of MSMS.

They are joining together because they believe there must be a strong, organized effort from medicine, if the best interests of the profession and the public are to be served. In most of these critical areas, ethical and educational standards are most properly set, maintained and monitored by the profession itself.

Yet, if medicine is to influence national, state and local decisions, each physician must be willing to assume a leadership role. Each physician must be willing to accept appointments to committees, to accept interviews from the media or speak to groups when invited. Each physician must be willing to give time and support to elect delegates and officers who are competent and informed.

With your support and active participation in the activities of your local society, the MSMS can assure that your voice will be heard.



Anticipating a drive soon to gain more MSMS members are, from left to right, John R. Ylvisaker, MD, Pontiac, MSMS president; Marcia Rohrer, MD, Mason; Robert D. Burton, MD, Grand Rapids, chairman, MSMS Committee on Member Services, and Thomas C. Payne, MD,

Lansing, chairman, Michigan Doctors Political Action Committee. This month's special report talks about MSMS membership recruitment strategy, while this issue contains several membership benefit inserts. (Photo by Merv Scholten, MSMS staff)

MICHIGAN MEDICINE

December 1980, Vol. 79, No. 35

Special report

- 616** MSMS is gearing itself for a major membership recruitment drive — and the goal is 10,000 MSMS members. Special articles in this issue describe the data gathered and the thoughts of the MSMS Committee on Membership Recruitment and Retention; provide a comparison of MSMS membership dues to those of other professional groups; describe why one new member joined MSMS and appeal for greater medical society work with medical students, interns and residents; Joseph A. Arends, MD, and Billy Ben Baumann, MD

MSMS members, and MDs interested in joining MSMS, are invited to remove and save two special publications on MSMS member benefits and activities bound here in the magazine. The "MSMS at Work" brochure and the fold-out on MSMS benefits, especially insurance programs, provide up-to-date, useful information for every Michigan physician.

Features

- 624** Refugee report: How Indochinese refugees view medical care systems; Steve Grizzell, Joyce Savale, Phil Scott, and Nguyen Tuong
- 631** Congress is moving toward the private health care system, MDs learn at the First Annual MSMS Public Affairs/Leadership Conference; Judith Marr
- 634** MSMS Bureau of Economics continues its reports on medical malpractice claims filed in Michigan; John A. Richards
- 643** Physicians working in HMOs generally report a favorable experience; Dwight Angell
- 645** The Health Alliance Plan and Michigan Master Medical Plan provide good contrast in HMOs; Shelton Reece
- 650** Bob Hope reports laughter is the extra ingredient which keeps him young; Willah Weddon
- 653** Smalltown: A case history of physician retentionitis; Charles R. Downs

Departments

- 614** Editorial
- 615** Letters
- 621** Health planning update
- 622** Committees
- 648** Views; Frederick C. Swartz, MD
- 656** News
- 658** Category I meetings
- 660** Meetings
- 662** New members
- 665** Deaths
- 666** Ad index
Classified ads
- 668** President's page; John R. Ylvisaker, MD

MPMLC deserves support of every Michigan physician

Elsewhere in this issue we are printing an advertisement for the Physicians Insurance Company of Michigan. PICOM is the Michigan subsidiary of an Ohio-based company. It replaced the defunct Brown McNeely Insurance Fund in July 1980.

As members of the MSMS Committee on Publications, we have agreed to accept this ad in the spirit of competition and fair play.

We want to make it clear, however, that the PICOM is very new on the state's medical malpractice insurance scene, and should not be confused with the established, MSMS-endorsed Michigan Physicians Mutual Liability Company (MPMLC).

MPMLC was founded in 1975 by members of the Michigan State Medical Society to help physicians obtain professional liability insurance at a time when there was a crisis of insurance availability.

MPMLC is the company created for and by MSMS members. It has performed in an outstanding manner. It has grown to be the second largest writer of medical malpractice insurance in Michigan and is 25th largest in the U.S. MPMLC has steadily expanded its services and this year added Medgard — a total premises liability and property protection coverage. Twice it has lowered its rates, due to its fiscal soundness and the good performance of its policyholders. It is filing for a third rate reduction in the near future.

MPMLC has developed outstanding risk management and counseling services, also its own claims investigation procedures, to allow it to go to bat for physicians facing suits.

We understand some Michigan physicians have become confused by the entry of the new company into the professional liability insurance field, and think it is the same firm they've been hearing about and doing business with the past four to five years.

We have prepared this editorial to emphasize that MPMLC is your company, the only professional liability company endorsed by the MSMS Council. At its Sept. 22 meeting, the MSMS Council adopted the following resolution:

"Whereas, MPMLC is providing excellent insurance coverage to hundreds of medical and osteopathic physicians, has itself become financially viable, is independently managed and has proved itself in the marketplace, Resolved, that MSMS endorses and commends MPMLC for its substantial progress and suggests to all Michigan medical and osteopathic physicians that they may purchase malpractice and professional premises coverages from MPMLC with complete confidence in its stability and in the splendid character of the services it renders."

MPMLC has an excellent track record and good insurance rates. Surely the MPMLC's services, which have grown steadily and reputably at the hands of our fellow Michigan physicians, deserve the support of every MD and osteopathic physician in the state.

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 Busharat Ahmad, MD, Vice Chairman
 Harvey M. Andre, MD
 Vickers C. Hansen, MD
 James D. Fryfogle, MD
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 Charles L. Oppy, MD, Roscommon

Editor

Judith Marr

Michigan Medicine, the official journal of the Michigan State Society, is dedicated to provide useful information for Michigan physicians about actions of the Michigan State Medical Society and contemporary issues, with special emphasis on socio-economics, legislation and news about medicine in Michigan.

The Michigan State Medical Society Committee on Publications is the editorial board of Michigan Medicine and advises the editors in the conduct and policy of the magazine, subject to the policies of the MSMS Council.

Neither the editors nor the state medical society will accept responsibility for statements made or opinions expressed by any contributor in any article or feature published in the pages of the journal. The views expressed are those of the writer and not necessarily official positions of the society. Products and services advertised in Michigan Medicine are neither endorsed nor warrantied by MSMS.

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Muskegon physicians chastise DSS' John Dempsey

The following letter was mailed to the editor of *Michigan Medicine* so that it could be shared with all MSMS members. It was sent originally to John Dempsey, director, Michigan Department of Social Services.

We are writing to vigorously protest the decision of Governor William Milliken and the Department of Social Services to reduce Medicaid fees by 15 percent effective Dec. 15.

The undersigned represent a cumulative total of 57 years in pediatric practice in the Muskegon area. Never, since the induction of the Medicaid program in 1967, have we yet turned away a Medicaid eligible patient in need of pediatric care. At times, caring for our private patients was delayed or postponed in order to accommodate Medicaid recipients whose illness was more acute, thereby taking precedent.

Currently, Medicaid payments are less than 70 percent of our usual and customary fees. Requesting, or perhaps I should say demanding, that we accept an additional 15 percent less is asking us to subsidize the Medicaid recipient initially by paying Michigan state tax and subsequently by giving of our medical service at less than a "break-even" level.

This we will be unable to do if we are to continue to provide the same quality service to the Medicaid recipient as we do to our private patients.

In your letter, Mr. Dempsey, you ask that we "consider more than ever the cost of medical care for Medicaid patients."

May I ask you to do the same?

I have a suggestion for you. If each Medicaid recipient were compelled to pay \$1 to the medical provider for each Medicaid service rendered it would eliminate much of the abuse by Medicaid recipients who seek out unnecessary and repeated medical care at absolutely no cost to them. This, in turn, would enable

you to increase, not decrease the fee for medical service rendered at a time when all of our overhead expenses are increasing daily.

Most of us who work for a living have realized long ago that very few people appreciate anything in life which is given to them gratis.

As director of the Department of Social Services I would be ashamed to reach the conclusion that you have as a means of approaching the problem of reduced revenues in the state budget allocated for the Medicaid program. We ask that you rescind this decision immediately and consider other avenues which are more economically fair to all concerned.

Sincerely,

Howard V. Sanden, MD, FAAP

Lester C. Paterson, MD, FAAP

Barry W. Willbrandt, MD, FAAP

Pediatric Associates of Muskegon, PC

Thank you for recent MSMS conference

This letter is a note of appreciation for the recent Michigan State Medical Society Public Affairs Leadership Conference. This conference was indeed outstanding. The speakers and their subjects were timely and very worthwhile. I certainly wish that more members of the Kent County Medical Society would have been able to attend this meeting.

Again, congratulations to you and your staff for this fine conference. I certainly hope that this will be a tradition each year with the Michigan State Medical Society.

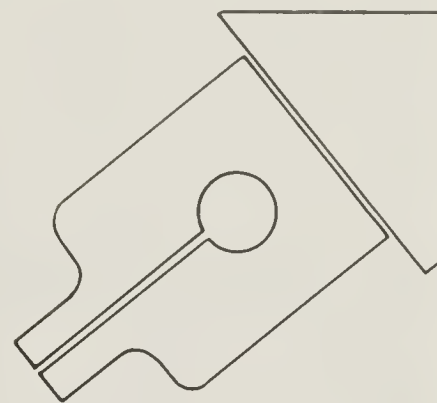
Sincerely,

Timothy M. Talbott, MD

President

Kent County Medical Society

Please see story and photos on the conference, pages 631-632.



Letter of appreciation

The following letter was mailed to John W. Vincent, MD, after his letter approving MPMLC advertisements in *Michigan Medicine* was printed in the journal.

I saw your letter in the September issue of *Michigan Medicine* and would like to thank you for both supporting our company and complimenting our July advertisement.

As you know, being a mutual company, we are your company. We are always very pleased to receive the support of our insured physicians. While we are not able to publish comments on the activities of our competitors, we believe the point in your letter was well taken.

Doctor Vincent, thank you again for your support. I would enjoy meeting you in person. We will have a booth at the MSMS Annual Scientific Meeting Nov. 18-19-20 at the Hyatt Regency Dearborn. Please stop by and say hello.

In the event you have any questions about the Michigan Physicians Mutual Liability Company, please call me in East Lansing on our toll free number (800-292-1926). We hope that there are many other physicians who feel as you do. We are trying very hard to achieve "greater participation (with our company) so that costs can be reduced for insurance coverage."

Sincerely,

Gary Brown

Vice President, Public Relations

Michigan Physicians Mutual

Liability Company

MSMS sets its sights on membership of 10,000 physicians



The Clarkston farm of James O'Neill, MD, was the setting of a picnic for prospective members, sponsored late in the summer by MSMS and the Oakland County Medical Society. At the membership recruitment event were, from left, Jack Hotaling, of the AMA Membership Department; Tom Prose, University of Michigan medical student; Billy Ben Baumann, MD, Pontiac, and Joseph A. Arends, MD, Troy, new MSMS member.

The number 10,000 is magic to the MSMS Committee on Membership Recruitment and Retention.

It is the membership goal the committee would like to see MSMS reach in a major new drive to spotlight the benefits of MSMS membership and to gain new members.

MSMS memberships are at an all-time high today, with 9,619 members as of October. That includes 8,202 dues-paying members and 1,417 dues-exempt members. By comparison, MSMS had 8,054 dues-paying members in 1979, 7,798 in 1978 and 7,702 in 1977.

This steadily-increasing membership looks pretty good, the committee acknowledges. Yet Billy Ben Baumann, MD, Pontiac, committee chairman, notes there is a sizable gap between the number of licensed Michigan physicians and the number of MSMS members.

It is to this gap that the committee is directing its efforts, preparing a special membership report containing major recommendations for increasing numbers of MSMS members.

What's to be done

The committee is recommending:

1) That MSMS adopt as minimum goals for membership recruitment for 1981: 300 new dues-paying members, 150 new Michigan AMA members, 300 resident members and 100 student members.

2) That MSMS offer one or more recruitment training techniques workshops for concerned, interested physicians and staff members to prepare them for one-on-one recruitment efforts, and

3) That MSMS use existing direct-mail recruitment techniques and, with AMA expertise, develop additional direct mail efforts.

From the best data the committee was able to obtain, reports Doctor Baumann, there are just over 14,000 licensed Michigan physicians, of whom 2,500 are residents-in-training. Of the remaining 11,500 licensees, there are an indeterminant number residing outside Michigan.

The committee concluded, however, there are approximately 1,100

to 1,500 non-members in the state, excluding the residents, who are potential MSMS members.

The committee believes that MSMS recruitment efforts for 1981 should have as priorities:

1) Practicing physicians in major population centers.

2) Residents in Michigan training programs.

3) Academic physicians at the three medical schools.

4) Foreign medical graduates practicing in Michigan.

5) Medical students at U-M, Wayne and MSU.

Furthermore, the committee believes MSMS should concentrate efforts in counties where there are the greatest numbers of non-members: Wayne, Oakland, Washtenaw, Macomb, Kent, Ingham and Genesee.

How it's to be done

The committee proposes several methods for recruiting new members.

These methods include direct mailings to the groups most sought as members, and doctor-to-doctor contacts including personal letters of welcome and invitation to every new physician in an area; telephone membership solicitation campaigns and lists of non-members on hospital staffs who may be contacted.

The committee recommends that every component society of 100 members or more establish a membership committee.

The committee believes it would help greatly for MSMS to work jointly with the AMA, which can provide expertise in direct mailings and other solicitation techniques, as well as provide data to assist in membership recruitment.

The committee recommends closer work with the Michigan Health Council and the Board of Medicine, both of which have contacts with physicians who may not be MSMS members. The committee also believes a comprehensive membership solicitation and information kit

should be prepared to attractively detail MSMS membership services, benefits and programs.

"We are keenly aware," says Doctor Baumann, "that a recent AMA survey of both members and non-members was very revealing as to reasons for joining or not joining organized medicine.

"Most non-members said the cost was too high. On the basis of this knowledge, MSMS is clearly mandated to open every possible channel of communication to explain MSMS services and benefits in a clear, rational way which also establishes the cost-benefit ratio of membership."

The committee believes MSMS should re-examine its membership criteria and categories with an eye to streamlining them, and then to present a model system to component societies to help standardize membership processing, to make membership transfers simpler and to greatly aid recruitment efforts.

The Committee also believes MSMS should consider amending its constitution to permit direct resident and student membership in cases where component membership is not feasible or practical.

Current members important

Committee members are not neglecting the physicians who already are members. They are calling for an active field service to better inform members and help them with problems. The committee also sees a need for MSMS officers and councilors to travel more to meet with members.

"It is our perception that MSMS has numerous strengths and assets which we simply have to better advertise to our members and non-members alike," continues Doctor Baumann. "We see the need for open channels of communication between every MSMS committee, the Council, the staff and the membership as vital to our recruitment and retention efforts.

"Only an informed member can make rational decisions about an organization's worth.

"We also recognize there are multiple emotional reasons for belonging to any group and we believe MSMS must examine and research these thoroughly to present a salable package of membership. We must

strive to make membership meaningful."

The committee has further recommended MSMS carefully examine each of its present membership benefits to determine which are valuable and appropriate, and likewise examine its educational, informational, legislative, and public relations efforts with an eye to expanding them or using each to further enhance the value of membership.

"MSMS has enjoyed continuous growth over the years, and operates from a position of strength as far as membership is concerned," says Doctor Baumann. "This is no reason, however, to rest on our laurels. We

must aggressively recruit new members and retain our present members by communicating our value to them. We cannot afford to be complacent.

"We believe the recommendations and suggestions in our report are reasonable and appropriate, but are in themselves no magic answers. It will take a concerted effort by each member willing to recruit. And it also will require a commitment by MSMS to devote staff time and financial resources to do the job properly.

"We would like to see MSMS membership hit the 10,000 mark as soon as possible."

I Owe the Profession

By Joseph A. Arends, MD, Troy

I am 40 years of age and self-employed in the solo practice of preventive medicine. I am not attached to any hospital but function as an out-patient facility. I have a wife and three children who require a great deal of my time. I run 20 miles per week and coach my boys' basketball and soccer teams throughout the year.

Why then would I want to join the local county medical society, the Michigan State Medical Society and the American Medical Association? The reason to me is quite clear! I owe it to the profession.

There is no economic incentive for me to join and I do not have to join by necessity to practice medicine. However, in light of the benefits delivered by the profession over the past 150 years, I feel an obligation to pay back to the profession at least some of the good life that I enjoy in this country. I cannot think of any other country in the world where physicians live as well or as free, and

yet appreciate it less. Is it any wonder why physicians world-wide are scrambling to get into this country?

I have many reasons to thank the profession. I only hope that my meager economic support of the societies will help in their efforts for me. I am constantly reminded of their efforts for me when I think of the following:

- 1) Every time I receive the confidence and trust of a patient, I owe the profession.
- 2) Every time I examine a female without her husband being present, I owe the profession.
- 3) Every time I deliver and collect for services rendered, free of government interference, I owe the profession.
- 4) Every time I distribute MSMS and AMA literature and pamphlets for patient information, I owe the profession.
- 5) Every time I attend an MSMS or AMA postgraduate seminar, I owe the profession.

For these reasons I say thank you, and I hope that those good physicians who appreciate their way of life will join me in establishing and continuing their life-long membership in organized medicine.

Doctor Arends is joining The Oakland County Medical Society, Michigan State Medical Society, and The American Medical Association in 1980.

Membership dues — what do others really pay?

Every association depends on the dues voluntarily paid by its members to finance its activities, services and benefits. This fact is universal regardless of the organization — industrial, labor, marketing, social, or professional.

And every organization has members who ask about dues and benefits received, especially in times of inflation. Just as it is human nature to wonder how much someone else earns, it is natural to compare our dues payments to various organizations. While it is difficult to compare professional dues with dues paid to a local service club, lodge, country club or religious organization, it might be useful to compare dues paid by other professionals.

Since every MSMS member has at some time or another heard statements or comments about dues paid by other health professionals, the MSMS Membership Committee di-

rected staff to conduct a simple survey of Michigan-based health and medical organizations in an effort to set the record straight and present the findings for consideration.

The results of that survey are presented in the accompanying chart.

Various factors influence the amount of dues paid. The variety of services offered by an association, the number of members to share the costs, and the nature of the organization, must be taken into account as one attempts to analyze the dues structure.

MSMS also surveyed two union groups — teachers and auto workers — for further comparison.

In 1979, Michigan Education Association members (there are 85,000 of them) paid state dues amounting to \$187.10, plus National Education Association dues of \$42. The total was \$229.10. In addition they paid local dues, which ranged from \$15 to

nearly \$100. These amounts were not available to average.

Of interest in comparing teachers' dues with those of physicians is that teachers pay approximately one percent of their gross income in dues while physicians pay approximately ½ of one percent of gross income based on average income figures for all medical specialties as reported recently by *Medical Economics*.

United Auto Workers members pay the equivalent of two hours salary per month in dues. The 600,000 Michigan UAW members average \$240-\$260 per year in union dues — about 1 per cent of gross income exclusive of fringe benefits.

None of the figures shown in the chart includes dues for political actions arms of the respective organizations. PAC contributions are above and beyond any figures shown here.

1980 Membership Dues for Selected Health/Medical Professional Associations

Profession/Association	Number of Michigan Members	Local	Dues		Total
			State	National	
Podiatry Michigan State Podiatry Assoc.	351	\$ 60*	\$675 ¹	\$225	\$960
Optometry Michigan Optometric Association	625	\$75*	\$395	\$300 ²	\$770
Chiropractic Michigan State Chiropractic Assoc.	375	NA	\$400 ³	\$280	\$680‡
Osteopathy Michigan Association of Osteopathic Physicians and Surgeons	2816	NA	\$550	\$175	\$725
Medical Doctors MSMS	8300	\$100*	\$260 ⁴	\$250	\$610
Dentistry Michigan Dental Assoc.	4700	\$60*	\$210	\$150	\$420
Pharmacy Michigan Pharmacists Assoc.	3000	—	\$130/\$115 ⁵	\$ 65	\$180
Nursing Michigan Nurses Association	8000	NA	\$100	\$ 35	\$135

N.A. — Not Available or Not Applicable

*Indicates average or representative figure as local dues vary widely.

1. \$225 of this amount is earmarked for CME.

2. In addition to this figure, members are paying an additional \$200 annual "communications assessment."

3. Chiropractic dues are pro-rated for the first five years; This figure is the amount paid by a member in the fifth year and subsequently.

4. This figure is for 1981 dues which reflects the \$10 increase authorized by the House of Delegates for an expanded PR/Communications Program.

5. Figure of \$130 is for pharmacist who joins state only. Pharmacists joining the national organization pay \$115, since \$15 of the national dues reverts back to state group.

Medical students need not apply?

By Billy Ben Baumann, MD, Pontiac

A professional baseball team without a "farm system?" A factory owner that refuses to replace worn-out machines? A farmer that refuses to put seeds into the soil? Which of these images most resembles a medical society devoid of medical student members?

The consequences to the baseball team, factory owner, and farmer are painfully predictable. For the medical society, I fear equally disastrous results: slow (or no) growth of total membership, declining revenues, diminished ability to shape the future of medical practice and resist the intrusions of government. We will have young physicians, practicing in our midst, but not a part of MSMS, not working for the goals that you and I share. Some may even be working against those goals.

For, indeed, there are those forces in and about the medical school campus which are active and effective in recruiting medical students into organizations or ways of thinking about medical practice that many of us would regard as alien.

We are not a force on the medical campus. In the "war" for minds and hearts of our next generation of physicians, we have not even bothered to search for the battlefield: we have defaulted.

There's even more tragedy here. Many of these students want us to pay attention to them! I have discussed organized medicine with several students in recent months. The main reason that our medical students and so many young physicians ignore organized medicine is that they've never been asked to pay attention to it! Given the opportunity, they are receptive, even eager to learn from experienced, practicing physicians. They are eager to hear our views and to join with us in achieving common goals.

Why have students been ignored

Doctor Baumann is chairman of the MSMS Committee on Membership Recruitment and Retention.



by MSMS (and most other state and county medical societies)?

One reason is, of course, that they're "just whippersnappers," and have nothing to offer by way of ideas or experience. Perhaps. But I strongly believe otherwise and, having observed the social changes of the past 20 years, I suggest that you do so also. Another reason they have been ignored is that they don't pay their way, they're a financial liability. To any of us who would use that as an excuse, may I ask: Aren't you a little like the baseball team owner, the factory owner and the farmer who opened this essay? Aren't you refusing to make a needed capital investment in a crucially important enterprise — the medical federation in the USA?

There are approximately 2,200 medical students attending the three allopathic schools in Michigan. For the long-range good of our profession in Michigan and nationally we must invest the money and effort now to

begin to bring these young people into the MSMS fold. If we don't do it now, the task will only become more difficult in the future and the growth of MSMS and the AMA will continue to lag the growth in the number of licensed physicians.

We must begin now to eliminate barriers to membership in MSMS and we must begin to lay the groundwork for effective "Student Business Sections" originating on our three campuses and extending through MSMS to the AMA. With strong AMA Student Business Sections on each campus and an open sharing and supportive attitude by MSMS, we can recruit large numbers of students into membership. The financial benefits to MSMS will be negative in the beginning, of course. But we will have done a great service for these students and for the future of the medical profession in the United States. I ask you to believe in this effort and support it whenever and however you are able.

half-life

Just one built-in advantage

Ensures smooth therapeutic effect even if a dose is missed The relatively longer half-life of Valium® (diazepam/Roche) has important clinical and pharmacological implications. Steady-state levels generally are reached within 5-7 days with no further accumulation. At this plateau, the patient benefits from the consistent, steady response you expect. Sharp blood level variations, frequently attributed to agents with a short half-life, do not appear with Valium.

Avoids sudden symptom breakthrough

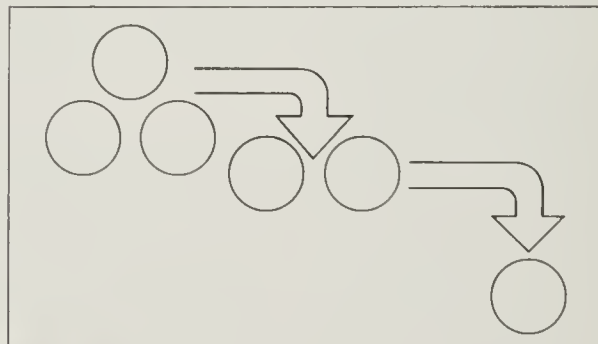
Once steady-state levels are achieved, sudden reemergence of symptoms is unlikely. Diazepam and its active metabolites exhibit overlapping half-lives that are advantageous not only during therapy but especially when pharmacologic support is discontinued. Elimination rates are gradual with Valium and thus provide a compatible adjustment interval for

the patient. In comparison, blood levels of short-acting agents with inactive metabolites decrease more rapidly and are more likely to be associated with withdrawal symptoms if medication is stopped abruptly.* With Valium unwanted effects other than drowsiness or ataxia are rare. Patients should be cautioned about driving and advised to avoid alcohol.

Tapers naturally; complements gradual dosage reduction at discontinuation

When any psychoactive medication is discontinued, it is good medical practice to gradually reduce the dosage. From your own experience you know this is rarely necessary after a short course of Valium therapy, but for patients on extended therapy, gradual reduction of dosage is advisable. This regimen, along with the self-tapering feature of Valium, provides a smooth transition to independent coping.

*Sellers EM: *Drug Metab Rev* 8(1):5-11, 1978



*in the management of
symptoms of anxiety*

Valium®
diazepam®
2-mg, 5-mg, 10-mg scored tablets

*effective therapy through
efficient pharmacodynamics*

Before prescribing, please see summary of product information on next page



Valium® diazepam/Roche

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Management of anxiety disorders, or short-term relief of symptoms of anxiety, symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal, adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, atetosis, stiff-man syndrome, convulsive disorders (not for sole therapy)

The effectiveness of Valium (diazepam/Roche) in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma. may be used in patients with open angle glaucoma who are receiving appropriate therapy

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication, abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms similar to those with barbiturates and alcohol have been observed with abrupt discontinuation, usually limited to extended use and excessive doses. Infrequently, milder withdrawal symptoms have been reported following abrupt discontinuation of benzodiazepines after continuous use, generally at higher therapeutic levels, for at least several months. After extended therapy, gradually taper dosage. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence

Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed, drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported, should these occur, discontinue drug. Isolated reports of neutropenia, jaundice, periodic blood counts and liver function tests advisable during long-term therapy

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HEALTH PLANNING UPDATE

By Dennis Paradis, East Lansing



MSMS adopts new position on health planning law

PL 93-641, which is the federal mandate that created the current health planning structure, will terminate in 1982. In an effort to prepare for the Congressional debates to shape successor legislation, the MSMS Council adopted the following resolution at its Oct. 22 meeting:

RESOLVED: That the Council direct the MSMS delegation to the AMA House of Delegates to introduce a resolution in December supporting the AMA approach regarding PL 93-641 but also directing the AMA to seek repeal of the law for being cumbersome and ineffective as a health planning statute, or draft legislation to replace PL 93-641 with an alternative, or draft principles by which to assess amenatory or replacement language for PL 93-641.

The adoption of this resolution makes MSMS policy on PL 93-641 consistent with the AMA policy.

Despite the positions of MSMS and the AMA in opposition to the "cumbersome and ineffective" structure of PL 93-641, both organizations are on record as supporting local health planning and urge physicians to take an active part in this process. AMA and MSMS positions stress the importance of continuing physician involvement at the HSA level.

Study criticizes health planning effectiveness

A study conducted by the Codman Research Group, Inc. under a contract granted by the Department of Health and Human Services is critical of the effectiveness of health planning in the New England states. The study draws several conclusions about health planning in the New England states including: health planning is best viewed as a federal government effort, shared by some states, to control health care costs; health planning has not proven an effective control on the expansion of health care institutions; PL 93-641 is ineffective as a regulatory program; health resources allocation under PL 93-641 is accomplished primarily through political bargaining.

The two volume study is entitled "An Integrated Approach to Evaluating the Impact of Health Planning in New England" and is available through the National Technical Information Service, Port Royal Bend, Springfield, VA 21161.

Mr. Paradis is director, MSMS Physician/HSA Support Center.

COMMITTEES

New MSMS committee the link between area PSROs and state medical society

By Bonnie L. Groff, MSMS staff



Doctor Johnson, chairman, MSMS PSRO Liaison Committee.



At a recent meeting of the Statewide PSR Council were MSMS PSRO Liaison Committee members Daniel J. Fall, MD, Ann Arbor, left, who also is PSR Council chairman, and Frederick W. Van Duyne, MD, Flint.

In an effort to encourage its members to become involved in physician-controlled peer review, and to support physicians already involved, MSMS has created a PSRO Liaison Committee.

During the past few years, the PSROs of Michigan have come to be recognized as an important factor in quality assurance strategy and evaluation. However, the complete potential of PSROs to medicine, the public interest and health care reform has yet to be realized.

The main function of this new MSMS committee is to act as a formal liaison between MSMS and the 10 area PSROs as well as with the Michigan Statewide PSR Council. In addition, it will seek out information regarding the general status of the PSRO program on a national, regional and statewide level, and will coordinate and promote communications regarding the status and direction of medical peer review programs.

Other charges to the committee include supporting MSMS members involved in PSRO activities, reporting to The MSMS Council on impor-

tant matters and those where MSMS policy is pertinent, and acting as liaison with other MSMS committees whose range of activities may be affected by the PSRO Liaison Committee.

In the future, the PSRO Liaison Committee plans to solicit regular status reports and presentations from representatives of the PSR Council, from local PSROs and/or the PSRO Alliance and to coordinate and promote peer-review-related articles in Michigan Medicine and component society journals.

Other activities of the committee involve input and advice to PSROs and the PSR Council regarding organizational plans and/or activities which might further benefit MSMS members. The committee plans to channel MSMS ideas regarding cost-effective strategies for medical care delivery to PSROs and to the PSR Council.

At its Oct. 21 meeting, the committee decided to make application to the MSMS Annual Scientific Meeting Task Force to start work on a course to be presented at the 1981 Annual Scientific Meeting.

The committee also agreed to continue the regular feature articles on the status and direction of medical peer review programs now appearing in Michigan Medicine.

The members of the MSMS PSRO Liaison Committee are: Kenneth H. Johnson, MD, Lansing, Chairman; Frederick E. Ludwig, MD, Iron Mountain, delegate from PSRO Area I; James M. Greenwood, MD, Alpena, delegate from PSRO Area II; Charles W. Aldridge, Jr., MD, Grand Rapids, delegate from PSRO Area III; Frederick W. VanDuyne, MD, Flint, delegate from PSRO Area V; Bernard Smookler, MD, Lansing, delegate from PSRO Area VI; Robert E. Medlar, MD, Jackson, delegate from PSRO Area VII; George F. Newman, MD, Dearborn, delegate from PSRO Area VIII; John Bryan, MD, Royal Oak, delegate from PSRO Area IX; Harold L. Daly, MD, Albion, delegate from PSRO Area X and Daniel J. Fall, MD, Ann Arbor, Statewide PSR Council.

DESCRIPTION: Methyltestosterone is 17 β -Hydroxy-17-Methylandrosta-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunuchism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-puberal cryptorchidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric,

avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE**

REACTIONS: Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. In the male: Eunuchoidism and eunuchism, 10 to 40 mg. Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpuberal cryptorchism, 30 mg. **REFERENCE:** R. B. Greenblatt, M.D.; R. Witherington, M.D.; I. B. Sipahioğlu, M.D.: Hormones for Improved Sexuality in the Male and the Female Climacteric. *Drug Therapy*, Sept. 1976. **SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only.

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REFUGEE REPORT

Indochinese refugees have vastly different views and use of medical care system

By Steve Grizzell, Joyce Savale, Phil Scott, and Nguyen Tuong, Detroit



Gov. Milliken, left, during his November, 1979 visit to Cambodian refugee camps, talks with a local Army official.

The diversity of the Indochinese population belies attempts to generalize or stereotype behavior and beliefs about health.

Sophisticated urban-dwellers are familiar with the methods and the proper approach for utilizing the western medical system. Rural people tend to be much less familiar with the western system and to continue practices and beliefs that were valid in Southeast Asia.

It is important to realize the refugee is using a series of treatment procedures and facilities based on their worldview and previous experiences before he/she consults with a private physician.

We would like to share with you some of the experiences and expertise of the Michigan Indochinese Re-

settlement Office.

Recently we interviewed a Vietnamese physician. He told us the Indochinese individual tends to diagnose and treat himself to a far greater extent than does the typical American. This behavior reflects conditions in their respective homelands. Indochinese medical facilities are inadequate and concentrated in the large urban areas. Transportation is difficult and this discourages trips of long distance. Finally, western style health care is expensive and there is no health insurance to finance medical care.

The solution, in part, is health education. Information about the American medical system and health care financing will help the refugees to effectively use our system.

Refugees are much more likely to prescribe drugs and treat themselves than is the typical American. Refugees are used to acquiring many drugs over the counter in Southeast

Asia that are available in this country only by prescription. In the United States refugees may use large quantities of aspirin and non-prescription drugs before they seek treatment from a physician.

Besides western drugs the refugee is also accustomed to using traditional herbal and Chinese medicines. Thus, when the refugee seeks relief from a physician he already may be taking quantities of prescription and non-prescription drugs. Only when the refugee perceives the illness or injury as beyond his own expertise, may he seek treatment in the emergency rooms of hospitals.

The physician also is faced with behavior which makes history-taking and accurate diagnosis difficult. Refugees arrive in this country with incomplete or inaccurate health records. They seek treatment in emergency rooms and thus continue to fail to develop a recorded health history.

Describing symptoms

An important element that confuses accurate diagnoses is the Indochinese description of symptoms. Psychological or emotional problems are sometimes described with somatic symptoms. "Hot intestines" is a phrase used by Vietnamese to describe being under stress or nervousness. "Weak kidneys" is a very general term that may refer to any ailment in the posterior part of the trunk, including lower back pain, sexual impotence or a decrease in sexual drive.

It is important for the physician to ask the same question in a number of different ways. One Vietnamese physician counsels his American counterparts to listen to the details of the complaint and not pay so much attention to the terms used.

The physician is an authority figure and the refugee may pretend to

continued on page 628

The authors are with the Michigan Indochinese Resettlement program, Michigan Department of Social Services.

The primary beneficiaries of ORAL HYDERGINE® TABLETS, 1 mg (1 tab t.i.d.)

Each 1 mg Hydergine tablet contains dihydroergocornine mesylate 0.333 mg, dihydroergocristine mesylate 0.333 mg, and dihydroergocryptine (dihydro-alpha-ergocryptine and dihydro-beta-ergocryptine in the proportion of 2:1) mesylate 0.333 mg, representing a total of 1 mg.

They're in their late sixties, the beneficiaries of more liberal retirement laws and more enlightened attitudes toward the elderly. They're leading socially productive lives. But recently, without any clear cause, they had each begun to experience mild episodes of symptoms such as confusion, mood-depression, and dizziness. Their ability to function could have been jeopardized. That's when they became the beneficiaries of oral Hydergine therapy.



The still-functioning geriatric can benefit from Hydergine treatment

It is quite common for cognitive and emotional symptoms of deterioration to manifest gradually in the elderly. During this early stage, such symptoms are mild and more amenable to treatment. It is at this stage that Hydergine therapy has proved most effective. Patients tend to respond better, and with symptoms effectively relieved—or at least their progression retarded—the ability to function can be maintained.

Oral Hydergine tablets promote better patient compliance

Compared with the sublingual form, dosage administration is easier, with less need for supervision.

Contraindications: Hypersensitivity to the drug.

Precautions: Because the target symptoms are of unknown etiology, careful diagnosis should be attempted before prescribing Hydergine tablets and sublingual tablets.

Adverse Reactions: Serious side effects have not been found. Some sublingual irritation, transient nausea, and gastric disturbances have been reported. Hydergine tablets and sublingual tablets do not possess the vasoconstrictor properties of natural ergot alkaloids.

Dosage and Administration: 1 mg three times daily. Alleviation of symptoms is usually gradual and results may not be observed for 3–4 weeks.

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Before prescribing, see package insert for full product information.

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must What you should know about the Michigan Drug Substitution law

The state legislature has dramatically changed the lawful way of prescribing drugs and of writing a prescription. Until now, writing the brand name of a drug on the prescription was enough to ensure that the brand-name drug would

indeed be dispensed. Now that no longer suffices. Unless the physician takes the necessary extra steps, for many drugs the pharmacist may substitute an "equivalent" generic drug.

Key points for the physician in writing prescriptions

- The pharmacist shall not dispense a generically equivalent drug product if:
 - (a) The prescriber, in the case of a prescription in writing signed by the prescriber, writes in his own handwriting "dispense as written" or "D.A.W." on the prescription.
 - (b) The prescriber, having pre-printed on his prescription blanks the statement "another brand of a generically equivalent product, identical in dosage, form, and content of active ingredients, may be dispensed unless initialed "D.A.W."; writes the initials "D.A.W." in a space, box, or square adjacent to such statement.
 - (c) The prescriber, in the case of a prescription other than one in writing signed by the prescriber, expressly indicates the prescription is to be dispensed as communicated.

Rx

D.A.W.

Signature

The decisions the physician must make

The physician should acquaint himself with the newly mandated prescription language illustrated on the preceding page. This requires a distinct change from the way prescriptions were previously written.

The prescription may be filled generically unless the physician writes in his own handwriting "D.A.W." or "Dispense As Written." Only by adding this language can the physician ensure that the brand-name drug will be dispensed.

If the physician elects to permit substitution, no special indication need be made, since unless explicitly prohibited the pharmacist may substitute.

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understand or be afraid to contradict or disagree, rather than be impolite. It is important for the physician to explain the procedure and why it is being done.

The attitude and terms used by the physician also are important. Indochinese women are extremely modest and direct references to the genitals or sexual activity can alienate them. If the physician is utilizing an interpreter, it is wise for the physician to instruct the interpreter to be culturally sensitive and to interpret the physician's questions and directions in an appropriate manner. A direct question about frequency of sexual intercourse might cause the patient to become extremely embarrassed and then to fail to return to a physician.

Rapid relief

The Southeast Asian refugee has an expectation of rapid or immediate symptomatic relief. Refugees and other Third World peoples believe that an injection by a syringe is the most efficacious method of treatment. Other refugees believe in the therapeutic value of an X-ray. This can cause some problems in the treatment of tuberculosis, especially since the treatment regimen with INH can last extended periods of time with few apparent results. The refugee may come to believe he is cured because of an X-ray and cease taking the INH. The importance of continuing to take medication after the symptoms of the complaint has disappeared should be communicated to the refugee and emphasized. This is important for any long-term treatment regimen and not just for the treatment of tuberculosis.

Refugees also may switch physicians if they do not receive rapid symptomatic relief. The danger for the refugee is if he continues to take medicine prescribed by one physician and fails to communicate this to another physician. Success for a cure, of course, is attributed to the last physician who treated the refugee.

There is no surefire approach for relating to the Indochinese patient. It requires an important skill that should be in the bag of every physician; sensitivity to the ethnicity and health beliefs of their patients.

Buy the gift of life — contribute to Michigan Refugee Relief Fund

Four carefully executed "mercy missions" to refugee camps in Cambodia are among the results of Michigan's own statewide refugee relief drive.

The Michigan Refugee Relief Fund, established a year ago by Governor Milliken following his personal visit to the refugee camps, is seeking Michigan physicians' donations. Michigan doctors' donations to date helped fund those four dramatic mercy missions in late August and early September.

Here are some figures to help comprehend the magnitude of gifts:

\$1,500 will buy 5 tons of rice

\$1,000 will buy 20 deepwell pumps for village water

\$500 will buy fish and rice for 100 women and children for one month

\$300 will buy A and D vitamins for 1,000 children for one month

\$250 will buy fish and rice for 10 families of five for one month

\$210 will buy 1,000 pounds of skim milk powder

\$170 will buy 100,000 multi-vitamins with iron

\$60 will buy fish and rice for 10 men for one month

Any contribution will buy the gift of life for suffering humanity in those Southeast Asian refugee camps.

Physicians may send their contributions to the Michigan Refugee Relief Fund, Box 55-316 A, Detroit, MI 48255.

Current Indochinese refugee population in the U.S. by state as of Sept. 15, 1980

Alabama	2,083
Alaska	309
Arizona	2,931
Arkansas	2,914
California	130,861
Colorado	7,968
Connecticut	3,806
Delaware	234
District of Columbia	5,386
Florida	8,185
Georgia	4,281
Hawaii	5,977
Idaho	727
Illinois	14,808
Indiana	3,675
Iowa	6,528
Kansas	5,117
Kentucky	1,939
Louisiana	10,567
Maine	632
Maryland	3,930
Massachusetts	5,887
Michigan	7,253
Minnesota	13,177
Mississippi	1,212
Missouri	3,789
Montana	1,076
Nebraska	2,202
Nevada	2,041

New Hampshire	287
New Jersey	3,577
New Mexico	2,135
New York	12,002
North Carolina	3,703
North Dakota	683
Ohio	5,656
Oklahoma	6,117
Oregon	12,529
Pennsylvania	16,522
Rhode Island	2,432
South Carolina	1,366
South Dakota	768
Tennessee	4,056
Texas	36,691
Utah	5,399
Vermont	203
Virginia	10,575
Washington	16,896
West Virginia	402
Wisconsin	5,528
Wyoming	294
Virgin Islands	11
Guam	391
Puerto Rico	28
UNKNOWN	1,475

TOTAL 409,221

The figures above come from Refugee Reports, a newsletter published biweekly by the Refugee Resettlement Information Exchange Project, Office of Refugee Resettlement, Department of Health and Human Services.

WHEN ANXIETY AND TENSION MAGNIFY PAIN

IN MUSCULOSKELETAL
DISEASE*



A non-narcotic one-two punch against pain, with concurrent relief of anxiety/tension

EQUAGESIC[®]™

(meprobamate and ethoheptazine citrate with aspirin) Wyeth

EQUAGESIC—Abbreviated Summary

INDICATIONS: Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:

"Possibly" effective for the treatment of pain accompanied by tension and/or anxiety in patients with musculoskeletal disease or tension headache. Final classification of the less-than-effective indications requires further investigation.

The effectiveness of Equagesic in long-term use, i.e. more than four months, has not been assessed by systematic clinical studies. The physician should periodically reassess usefulness of the drug for the individual patient.

CONTRAINDICATIONS: Equagesic should not be given to individuals with a history of sensitivity or severe intolerance to aspirin, meprobamate, or ethoheptazine citrate.

WARNINGS: Careful supervision of dose and amounts prescribed for patients is advised, especially with those patients with known propensity for taking excessive quantities of drugs. Excessive and prolonged use in susceptible persons, e.g., alcoholics, former addicts, and other severe psychoneurotics, has been reported to result in dependence on or habituation to the drug. Where excessive dosage has continued for weeks or months, dosage should be reduced gradually rather than abruptly stopped, since withdrawal of a "crutch" may precipitate withdrawal reaction of greater proportions than that for which the drug was originally prescribed. Abrupt discontinuance of doses in excess of the recommended dose has resulted in some cases in the occurrence of epileptiform seizures.

Special care should be taken to warn patients taking meprobamate that tolerance to alcohol may be lowered with resultant slowing of reaction time and impairment of judgement and coordination.

USAGE IN PREGNANCY AND LACTATION: An increased risk of congenital malformations associated with the use of minor tranquilizers (meprobamate, chlorid-

azepoxide, and diazepam) during the first trimester of pregnancy has been suggested in several studies. Because use of these drugs is rarely a matter of urgency, their use during this period should almost always be avoided. The possibility that a woman of child-bearing potential may be pregnant at the time of institution of therapy should be considered. Patients should be advised that if they become pregnant during therapy or intend to become pregnant they should communicate with their physicians about the desirability of discontinuing the drug.

Meprobamate passes the placental barrier. It is present both in umbilical-cord blood at or near maternal plasma levels and in breast milk of lactating mothers at concentrations two to four times that of maternal plasma. When use of meprobamate is contemplated in breast-feeding patients, the drug's higher concentrations in breast milk as compared to maternal plasma levels should be considered.

Preparations containing aspirin should be kept out of the reach of children. Equagesic is not recommended for patients 12 years of age and under.

PRECAUTIONS: Should drowsiness, ataxia, or visual disturbance occur, the dose should be reduced. If symptoms continue, patients should not operate a motor vehicle or any dangerous machinery.

Suicidal attempts with meprobamate have resulted in coma, shock, vasomotor and respiratory collapse, and anuria. Very few suicidal attempts were fatal, although some patients ingested very large amounts of the drug (20 to 40 gm). These doses are much greater than recommended. The drug should be given cautiously and in small amounts to patients who have suicidal tendencies. In cases where excessive doses have been taken, sleep ensues rapidly and blood pressure, pulse, and respiratory rates are reduced to basal levels. Hyperventilation has been reported occasionally. Any drug remaining in the stomach should be removed and symptomatic treatment given. Should respiration become very shallow and slow, CNS stimulants, e.g., caffeine, Metrazol, or am-

phetamine, may be cautiously administered. If severe hypotension develops, pressor amines should be used parenterally to restore blood pressure to normal levels.

ADVERSE REACTIONS: A small percentage of patients may experience nausea with or without vomiting and epigastric distress. Dizziness occurs rarely when meprobamate and ethoheptazine citrate with aspirin is administered in recommended dosage. The meprobamate may cause drowsiness but, as a rule, this disappears as therapy is continued. Should drowsiness persist and be associated with ataxia, this symptom can usually be controlled by decreasing the dose, but occasionally it may be desirable to administer central stimulants such as amphetamine or mephentermine sulfate concomitantly to control drowsiness.

A clearly related side effect to the administration of meprobamate is the rare occurrence of allergic or idiosyncratic reactions. This response develops, as a rule, in patients who have had only 1-4 doses of meprobamate and have not had a previous contact with the drug. Previous history of allergy may or may not be related to the incidence of reactions.

Mild reactions are characterized by an itchy urticarial or erythematous maculopapular rash which may be generalized or confined to the groin. Acute nonthrombocytopenic purpura with cutaneous petechiae, ecchymoses, peripheral edema and fever have also been reported.

More severe cases, observed only very rarely, may also have other allergic responses, including fever, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anaphylaxis, stomatitis and proctitis (1 case), and hyperthermia. Treatment should be symptomatic such as administration of epinephrine, antihistamine, and possibly hydrocortisone. Meprobamate should be stopped, and re-institution of therapy should not be attempted.

Rare cases have been reported where patients receiving meprobamate suffered from aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis, and hemolytic anemia. In nearly every instance reported, other toxic agents known to have caused these conditions have been associated with meprobamate. A few cases of leukopenia during

continuous administration of meprobamate are reported, most of these returned to normal without discontinuation of the drug.

Impairment of accommodation and visual acuity has been reported rarely.

OVERDOSE: Two instances of accidental or intentional significant overdosage with ethoheptazine citrate combined with aspirin have been reported. These were accompanied by symptoms of CNS depression, including drowsiness and light-headedness, with uneventful recovery. However, on the basis of pharmacological data, it may be anticipated that CNS stimulation could occur. Other anticipated symptoms would include nausea and vomiting. Appropriate therapy of signs and symptoms as they appear is the only recommendation possible at this time. Overdosage with ethoheptazine combined with aspirin would probably produce the usual symptoms and signs of salicylate intoxication. Observation and treatment should include induced vomiting or gastric lavage, specific parenteral electrolyte therapy for ketoacidosis and dehydration, watching for evidence of hemorrhagic manifestations due to hypoprothrombinemia which, if it occurs, usually requires whole-blood transfusions.

DESCRIPTION: Each Equagesic tablet contains 150 mg meprobamate, 75 mg ethoheptazine citrate and 250 mg aspirin.

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*This drug has been evaluated as possibly effective for this indication.

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of acetaminophen
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of two complementary
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economy of a
dosage schedule of
one tablet, every four
hours as needed



WHY NOT WYGESIC®

(65 mg propoxyphene HCl and 650 mg acetaminophen) Wyeth

WYGESIC—Abbreviated Summary

INDICATION: For the relief of mild-to-moderate pain.
CONTRAINDICATION: Hypersensitivity to propoxyphene or to acetaminophen.

WARNINGS: CNS ADDITIVE EFFECTS AND OVERDOSAGE: Propoxyphene in combination with alcohol, tranquilizers, sedative-hypnotics, or other CNS depressants has an additive depressant effect. Patients taking this drug should be advised of the additive effect and warned not to exceed the dosage recommended. Toxic effects and fatalities have occurred following overdoses of propoxyphene alone or in combination with other CNS depressants. Most of these patients had histories of emotional disturbances or suicidal ideation or attempts, as well as misuse of tranquilizers, alcohol, or other CNS-active drugs. Caution should be exercised in prescribing large amounts of propoxyphene for such patients (see **Management of Overdose**).

DRUG DEPENDENCE: Propoxyphene can produce drug dependence characterized by psychic dependence and less frequently, physical dependence and tolerance. It will only partially suppress the withdrawal syndrome in individuals physically dependent on morphine or other narcotics. The abuse liability of propoxyphene is qualitatively similar to codeine's although quantitatively less, and propoxyphene should be prescribed with the same degree of caution appropriate to the use of codeine.

USAGE IN AMBULATORY PATIENTS: Propoxyphene may impair the mental and/or physical abilities required for potentially hazardous tasks, e.g. driving a car or operating machinery. Patients should be cautioned accordingly.

USAGE IN PREGNANCY: Safe use in pregnancy has not been established relative to possible adverse effects on fetal development. **INSTANCES OF WITHDRAWAL SYMPTOMS IN THE NEONATE HAVE BEEN REPORTED FOLLOWING USAGE DURING PREGNANCY.** Therefore, propoxyphene should not be used in pregnant women unless, in the

judgement of the physician, the potential benefits outweigh the possible hazards.

USAGE IN CHILDREN: Propoxyphene is not recommended for children because documented clinical experience has been insufficient to establish safety and a suitable dosage regimen in the pediatric group.

PRECAUTIONS: Confusion, anxiety, and tremors have been reported in a few patients receiving propoxyphene concomitantly with orphenadrine. The CNS depressant effect of propoxyphene may be additive with other CNS depressants, including alcohol.

ADVERSE REACTIONS: The most frequent adverse reactions are dizziness, sedation, nausea, and vomiting. These seem more prominent in ambulatory than in nonambulatory patients; some of these reactions may be alleviated if the patient lies down.

Other adverse reactions include constipation, abdominal pain, skin rashes, light-headedness, headache, weakness, euphoria, dysphoria, and minor visual disturbances. The chronic ingestion of propoxyphene in doses over 800 mg per day has caused toxic psychoses and convulsions. Cases of liver dysfunction have been reported.

DRUG INTERACTIONS: Propoxyphene in combination with alcohol, tranquilizers, sedative-hypnotics, and other CNS depressants has an additive depressant effect. Patients taking this drug should be advised of the additive effect and warned not to exceed the dosage recommended. (see **Warnings**) Confusion, anxiety, and tremors have been reported in a few patients receiving propoxyphene concomitantly with orphenadrine.

MANAGEMENT OF OVERDOSAGE: SYMPTOMS The manifestations of serious overdose with propoxyphene are similar to those of narcotic overdose and include respiratory depression (a decrease in respiratory rate and/or tidal volume, Cheyne-Stokes respiration, cyanosis), extreme somnolence progressing to stupor or coma, pupillary constriction, and circulatory collapse. In addition to these characteristics, which are reversed by narcotic antago-

nists such as naloxone, there may be other effects. Overdoses of propoxyphene can cause delay of cardiac conduction as well as focal or generalized convulsions, a prominent feature in most cases of severe poisoning. Cardiac arrhythmias and pulmonary edema have occasionally been reported, and apnea, cardiac arrest, and death have occurred.

Symptoms of massive overdose with acetaminophen may include nausea, vomiting, anorexia, and abdominal pain, beginning shortly after ingestion and lasting for 12 to 24 hours. However, early recognition may be difficult since early symptoms may be mild and nonspecific. Evidence of liver damage is usually delayed. After the initial symptoms, the patient may feel less ill; however, laboratory determinations are likely to show a rapid rise in liver enzymes and bilirubin. In case of serious hepatotoxicity, jaundice, coagulation defects, hypoglycemia, encephalopathy, coma, and death may follow. Renal failure due to tubular necrosis, and myocardopathy, have also been reported.

Ingestion of 10 grams or more of acetaminophen may produce hepatotoxicity. A 13-gram dose has reportedly been fatal.

TREATMENT: Primary attention should be given to the reestablishment of adequate respiratory exchange through provision of a patent airway and institution of assisted or controlled ventilation. The narcotic antagonists, naloxone, nalorphine, and levallorphan, are specific antidotes against the respiratory depression produced by propoxyphene. An appropriate dose of one of these antagonists should be administered, preferably IV, simultaneously with efforts at respiratory resuscitation and the antagonist should be repeated as necessary until the patient's condition remains satisfactory. In addition to a narcotic antagonist, the patient may require careful titration with an anticonvulsant to control seizures. Analeptic drugs (e.g. caffeine or amphetamine) should not be used because of their tendency to precipitate convulsions.

Oxygen, IV fluids, vasopressors and other supportive measures should be used as indicated. Gastric lavage may be helpful. Activated charcoal can absorb a significant amount of ingested propoxyphene. Dialysis is of little value in poisoning by propoxyphene alone. Acetaminophen is rapidly absorbed, and efforts to remove the drug from the body should not be delayed. Copious gastric lavage and/or induction of emesis may be indicated. Activated charcoal is probably ineffective unless administered almost immediately after acetaminophen ingestion. Neither forced diuresis nor hemodialysis appears to be effective in removing acetaminophen. Since acetaminophen in overdose may have an antidiuretic effect and may produce renal damage, administration of fluids should be carefully monitored to avoid overload. It has been reported that mercaptamine (cysteine) or other thiol compounds may protect against liver damage if given soon after overdose (8-10 hours). N-acetylcysteine is under investigation as a less toxic alternative to mercaptamine, which may cause anorexia, nausea, vomiting, and drowsiness. Appropriate literature should be consulted for further information. (JAMA 237:2406-2407, 1977)

Clinical and laboratory evidence of hepatotoxicity may be delayed up to one week. Acetaminophen plasma levels and half-life may be useful in assessing the likelihood of hepatotoxicity. Serial hepatic enzyme determinations are also recommended.

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Congress leaning toward private health care system; voice of reason occasionally heard in capitol

By Judith Marr, Editor

Americans today need free choices in their health care delivery systems.

That is the assessment of Michigan's Democratic US Senator Carl Levin, who spoke during the morning session of the First Annual MSMS Public Affairs/Leadership Conference Oct. 30 at Long's Convention Center, Lansing.

Sen. Levin shared with 200 MSMS members, leaders and guests some perspectives gained from his experiences in Washington.

His audience was perhaps most heartened by his views:

1) "We need a pluralistic, competitive system for delivery of health care;" and,

2) "I don't think there is any massive support in Congress for a government-operated health care industry. The support of years ago is waning," he said. "There is growing sentiment to provide services not provided now through the private system."

Regulatory reform

Senator Levin described his keen interest in the area of regulatory reform. It was due to his request, he said, that the Oversight Subcommittee of the US Senate's Governmental Affairs Committee was reactivated in 1978. He now chairs that subcommittee. (Following the elections, however, Sen. Levin said he would lose that chairmanship, as control of the Senate goes to the Republicans.)

The shadow of current legal battles with the Federal Trade Commission over them, MSMS leaders listened intently to Sen. Levin's report of his efforts to introduce Congressional veto power over governmental agencies' regulations.

"I want to report to you there is movement in this area; there is a growing mood in Congress for regulatory reform," Sen. Levin said. "Perhaps more than any other, the health care industry understands



Sen. Levin addressing the 1980 MSMS Public Affairs/Leadership Conference.

how important it is to move away from the intensive red tape we've had in government."

He has been most involved in the legislative veto area, he said. "I want to induce accountability by introducing Congressional veto power to agencies' actions. I believe this is a critical element of Democracy."

Sen. Levin is co-sponsor, with Sen. David Boren (D-Oklahoma), of a bill which would allow Congress time to effect a two-house legislative veto over regulations before they are put into effect. The bill is on the Senate floor and has a good chance of seeing action in this lame duck session, he said. "It's all agencies we have to do this for," he said.

Two precedents for this two-house veto have been set — one on a recent HUD authorization bill, and another on an FTC bill. "It is long overdue," said Sen. Levin, "that Congress have the power to say 'no' in some simple and direct way to the FTC before its regulations are enforced."

How would this help MDs?

"If the FTC ever tried to get jurisdiction over trade practices of professionals, there would be some mechanism in place for Congress to veto," he said.

All is not going smoothly for the two-house veto, however, said Sen. Levin.

The US Attorney General has said the Levin-Boren bill, and the two-house vetoes attached to the HUD and FTC bills are unconstitutional, and the President can ignore them. Sens. Levin and Boren are fighting that ruling with an amendment to their bill which prohibits the use of funds by the executive branch to enforce a regulation after Congress vetoes it.

Sen. Levin is one of only three persons in Washington who have been helpful to MSMS during the recent MSMS/FTC litigation, said MSMS legal counsel A. Stewart Kerr earlier in the morning session.

During a question and answer period immediately following his



Mr. Scammon

talk, Sen. Levin explained that Congressional ethics limit his intervention in the MSMS/FTC affair to procedural questions, however.

Shaving votes

Sen. Levin was "shaving the opposition votes" as he spoke to the mostly Republican audience of physicians and guests, wryly noted national elections expert Richard Scammon, the morning's other headline speaker.

Rallying the faithful, getting as good a shake as possible from independents and neutrals and "shaving the opposition" are prime vote-getting methods, said Mr. Scammon as he spoke just days before the 1980 presidential elections.

He described "shaving" as the attempt to get at least some of those who normally don't vote for a candidate to change their votes. He said, "If he (Levin) can begin today to neutralize some of the opponents — an operation sometimes called 'defanging' — they may not vote for him, but they also may not contribute to the opponent. This can't escape the mind of someone who is going to run for election a few years from today."

Mr. Scammon, director since 1955 of the Elections Research Center, Washington, DC, said he has a fairly optimistic view of the American voter. "The voter's a lot smarter than the pollsters and pundits say," he observed.

"When push comes to shove, the people have a capacity for making realistic judgements." William F. Buckley, he said, claimed he'd rather be governed by the first 2,000 names in the Boston telephone book than by the whole Harvard faculty.

"The people listen, read and make up their own minds," he said — prophetically, as it turned out. "That's why I think so much of the American public. The voter may be inchoate, confused, semi-literate; but is so much better than any other."

Churchill, he said, claimed democracy was the worst government in the world, except for any other.

Mr. Scammon said he could not predict a winner in the presidential election, though his own research pointed to Reagan. He did say Congress was almost certain to get a Democratic majority again.

"But don't worry about it. All that means is more independents got elected under the Democratic label than under the Republican label." He characterized Congress as "generally an assembly of independents in which the voice of reason occasionally is heard."

Mr. Scammon and Sen. Levin were joined on the podium during the morning's session by MSMS President John R. Ylvisaker, MD, Pontiac; MSMS Council Chairman Louis R. Zako, MD, Dearborn Heights, and MDPAC Chairman Thomas C. Payne, MD, Lansing. Luncheon speaker was Robert T. Kelly, MD, Minnesota, AMA trustee.

The afternoons' session featured talks on MSMS activities, Blue Cross Blue Shield reform, Medicaid, HMO and IPA growth, PSROs and professional liability insurance. The final speaker was former AMA President Edward R. Annis, MD, Miami, FL.

Michigan legal cases of interest to MDs

Please see issue of AMA Citation newsletter cited for details of the cases listed here.

"Chiropractor To Be Tried For Unlawful Practices," Michigan Court of Appeals, Aug. 21, 1979, from the Citation, Vol. 41, No. 5.

"Citizens Lose Suit Opposing Sale of Hospital," Michigan Court of Appeals, Oct. 2, 1979, from the Citation, Vol. 41, No. 5.

"Michigan Court Reverse Decision In Favor of DES Manufacturers," Michigan Court of Appeals, Dec. 5, 1979, from the Citation, Vol. 41, No. 6.

"Patient With Nerve Injury Sues for Alleged Negligence," Michigan Court of Appeals, Sept. 10, 1979, from the Citation, Vol. 41, No. 6.

"Psychiatrist Charged With Unprofessional Conduct," Michigan Court of Appeals, Oct. 18, 1979, from the Citation, Vol. 41, No. 6.

"New Trial For Suit For Testicle Injury During Inguinal Hernia Surgery," Michigan Supreme Court, March 31, 1980, for the Citation, Vol. 41, No. 8.

"Patient Who Signed Form Does Not Have To Arbitrate," Michigan Court of Appeals, Jan. 22, 1980, from the Citation, Vol. 41, No. 9.

"No Negligence In Breast Cancer Postop Treatment," Michigan Court of Appeals, Feb. 5, 1980, from the Citation, Vol. 41, No. 9.

"Pharmacy's New Owners Not Liable For Previous Owner's DES Lawsuit," Michigan Court of Appeals, Feb. 20, 1980, from the Citation, Vol. 41, No. 9.

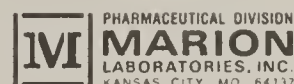


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ITS STYLE OF WIT, AND ITS OWN WAYS."

—from *The Art of Poetry* (1674) by Nicholas Boileau-Despréaux

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Average payout per Michigan malpractice claim continues to climb, MSMS study shows

By John A. Richards, East Lansing

The MSMS Bureau of Economics has reviewed 195 malpractice suits completing the legal process between June of 1979 and June 1980. Data from 1979-80 were compared with the information from the 906 suits previously analyzed. A total of 1,101 medical malpractice suits have

Mr. Richards is chief of the MSMS Bureau of Economics.

completed the legal process since 1975 and most have been studied by the MSMS Bureau.

While most characteristics displayed in the accompanying tables have remained stable, the average payout per claim has continued its upward trend. There is no reason to believe this trend will not continue.

Data on arbitration are not part of the present reporting system. Claims

processed through this system will be analyzed in a future article. The data presented in this article are confined to those claims completing the legal process through the court system.

MSMS would like to thank the Insurance Bureau and the Department of Licensing and Regulations for their assistance in completing this report.

Table I
Number of Claims by Year

	1970	1971	1972	1973	1974	1975	1976	1977	1978	1979	1980(1/2)
Number of Claims	5	6	26	72	189	267	254	165	77	31	2

Table II
Claims Characteristics

Year	1970	1971	1972	1973	1974	1975	1976
Number of Claims	5	6	26	72	189	267	254
Total Paid	\$16,667	\$44,220	\$569,262	\$740,051	\$1,777,484	\$2,649,970	\$2,158,470
Average Paid	\$3,333	\$7,366	\$21,894	\$10,278	\$9,405	\$9,925	\$8,498
% With no Indemnity Paid	(4)	(3)	(11)	(31)	(86)	(115)	(109)
	80%	50%	42%	43%	45%	43%	42%

Year	1977	1978	1979	1980(1/2)
Number of Claims	165	77	31	2
Total Paid	\$645,844	\$449,178	\$331,758	\$2,750
Average Paid	\$3,914	\$7,262	\$10,702	\$1,375
% With no Indemnity Paid	(71)	(34)	(3)	(0)
	43%	44%	9%	

Table III
Distribution by Thousands of Indemnity Paid

	1970	1971	1972	1973	1974	1975	1976	1977	1978	1979	1980(1/2)
\$ 0- 10	0	2	4	25	68	108	112	83	33	21	2
\$ 11- 20	1	0	3	6	9	20	11	4	4	4	0
\$ 21- 30	0	0	1	4	9	6	5	2	1	0	0
\$ 31- 40	0	1	0	2	2	1	2	1	2	1	0
\$ 41- 50	0	0	2	2	5	2	3	1	0	0	0
\$ 51- 60	0	0	1	0	0	3	2	2	0	0	0
\$ 61- 70	0	0	2	0	1	0	0	0	0	1	0
\$ 71- 80	0	0	0	1	2	3	1	1	0	0	0
\$ 81- 90	0	0	1	0	1	0	3	0	1	0	0
\$ 91-100	0	0	0	0	6	4	2	0	2	1	0
\$101-200	0	0	1	1	0	5	4	0	0	0	0

Table IV
Claims Reporting Data

	1970	1971	1972	1973	1974	1975	1976	1977	1978	1979	1980(1/2)
Number of Cases	5	6	26	72	189	267	254	165	77	31	3
Average Number of Months — Injury to Report	10	12	16	24	21	20	23	30	29	20	6
Average Number of Months — Injury to Close	85	69	73	70	59	49	45	42	36	24	6
Average Number of Months — Report to Close	75	57	56	47	39	29	22	13	7	4	-

Table V
Physician Characteristics

	1970	1971	1972	1973	1974	1975	1976	1977	1978	1979	1980(1/2)
Average Age of Physician	32	39	40	38	42	42	42	42	45	48	48
<i>Physician Age Distribution</i>											
30 and under	25%	20%	0	0	1%	1%	0	0	1%	0	0
31-40	25%	0	27%	22%	26%	27%	26%	32%	24%	25%	0
41-50	50%	40%	41%	43%	35%	34%	29%	28%	48%	32%	50%
51-60	0	40%	23%	12%	24%	19%	21%	22%	18%	35%	50%
60 and over	0	0	9%	5%	2%	9%	10%	6%	6%	6%	0
% of FMGs	N/A	33%	4%	10%	18%	21%	17%	19%	14%	19%	50%
Board Certified	(4) 80%	(5) 83%	(15) 58%	(47) 65%	(131) 69%	(162) 60%	(174) 68%	(100) 60%	(57) 74%	(18) 58%	(2) 100%

Table VI
Claims Against Physicians By Type of Practice

Type of Practice	1970	1971	1972	1973	1974	1975	1976	1977	1978	1979	1980(1/2)
Institutional	0	1	1	0	2	2	3	4	0	0	0
PC/Partnership	0	2	8	22	64	102	90	51	34	14	1
Self-Employed	5	3	16	45	114	146	151	97	38	17	1
Employed	0	0	1	5	7	14	9	10	4	0	0
Intern/Resident	0	0	0	0	0	0	0	0	0	0	0

Table VII
Suits by AMA Specialty Classification

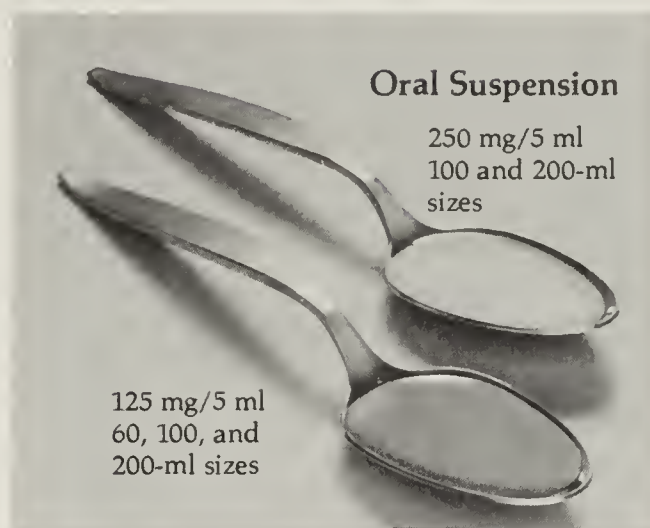
Allergy	3	Physical Medicine and Rehabilitation	6
Anesthesiology	20	Psychiatry	11
Cardiovascular Diseases	7	Pulmonary Diseases	1
Dermatology	7	Radiology, Diagnostic	19
Emergency Medicine	19	Rheumatology	2
Family Practice	28	Rhinology	7
Gastroenterology	3	Surgery, Abdominal	7
General Practice	176	Surgery, Cardiovascular	15
Geriatrics	1	Surgery, Colon and Rectal	1
Gynecology	26	Surgery, General	414
Internal Medicine	73	Surgery, Hand	3
Neurology	4	Surgery, Neurological	19
Neurology, Child	3	Surgery, Orthopedic	11
Nuclear Medicine	2	Surgery, Pediatric	7
Obstetrics	1	Surgery, Plastic	30
Ophthalmology	10	Surgery, Thoracic	18
Otology	1	Surgery, Traumatic	1
Otorhinolaryngology	7	Miscellaneous	30
Pathology	11		
Pediatrics	8		

Table VIII
Geographical Distribution of Claims

Zip Code	Counties Included	Number of Claims
480	Macomb, Oakland, St. Clair	290
481	Livingston, Monroe, Oakland, Washtenaw, Wayne	143
482	Wayne	236
484	Genesee, Huron, Lapeer, Oakland, Sanilac	10
485	Genesee	36
486	Arenac, Clare, Gladwin, Midland, Ogemaw, Oscoda, Roscommon, Saginaw	21
487	Alcona, Bay, Iosco, Tuscola	7
488	Clinton, Eaton, Gratiot, Ingham, Ionia, Isabella, Livingston, Shiawassee	27
489	Ingham	36
490	Allegan, Barry, Branch, Calhoun, Cass, Kalamazoo, St. Joseph, Van Buren	74
491	Berrien	0
492	Calhoun, Hillsdale, Ingham, Jackson, Lenawee	24
493	Kent, Lake, Mecosta, Montcalm	4
494	Mason, Muskegon, Newaygo, Oceana, Ottawa	26
495	Kent	29
496	Antrim, Benzie, Grand Traverse, Kalkaska, Leelanau, Manistee, Missaukee, Osceola, Wexford	16
497	Alpena, Charlevoix, Cheboygan, Chippewa, Crawford, Emmett, Luce, Mackinac, Montmorency, Otsego, Presque Isle	16
498	Alger, Delta, Dickinson, Marquette, Menominee, Schoolcraft	18
499	Baraga, Gogebic, Houghton, Iron, Keweenaw, Ontonagon	6

continued on page 638

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Table IX
Average Indemnity Paid by Geographic Region

Table X Others Contributing to Injury		Zip Code	Counties Included	Indemnity Paid
Attending Physician	230	480	Macomb, Oakland, St. Clair	\$ 6,956.12
House Staff	112	481	Livingston, Monroe, Oakland, Washtenaw, Wayne	11,327.98
Consultant	9	482	Wayne	8,122.81
RN	39	484	Genesee, Huron, Lapeer, Oakland, Sanilac	10,066.70
LPN	8	485	Genesee	7,789.31
Aid	0	486	Arenac, Clare, Gladwin, Midland, Ogemaw, Oscoda, Roscommon, Saginaw	2,028.57
Orderly	1	487	Alcona, Bay, Iosco, Tuscola	5,392.86
Pharmacist	1	488	Clinton, Eaton, Gratiot, Ingham, Ionia, Isabella, Livingston, Shiawassee	6,083.33
Radiologist	10	489	Ingham	2,867.22
Radiological Technician	5	490	Allegan, Barry, Branch, Calhoun, Cass, Kalamazoo, St. Joseph, Van Buren	10,781.72
Anesthesiologist	2	491	Berrien	-0-
Anesthetist	1	492	Calhoun, Hillsdale, Ingham, Jackson, Lenawee	6,797.92
Pathologist	5	493	Kent, Lake, Mecosta, Montcalm	797.42
Lab Technician	4	494	Mason, Muskegon, Newaygo, Oceana, Ottawa	3,861.92
Physician Assistant	7	495	Kent	14,524.07
Physical Therapist	2	496	Antrim, Benzie, Grand Traverse, Kalkaska, Leelanau, Manistee, Missaukee, Osceola, Wexford	25,788.53
Maintenance Personnel	1	497	Alpena, Charlevoix, Cheboygan, Chippewa, Crawford, Emmett, Luce, Mackinac, Montmorency, Otsego, Presque Isle	16,271.88
Others	16	498	Alger, Delta, Dickinson, Marquette, Menominee, Schoolcraft	5,280.28
Patient	11	499	Baraga, Gogebic, Houghton, Iron, Keweenaw, Ontonagon	6,125.00

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Librax

Please consult complete prescribing information, a summary of which follows:

Indications: Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows: "Possibly" effective as adjunctive therapy in the treatment of peptic ulcer and in the treatment of the irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis. Final classification of the less-than-effective indications requires further investigation.

Contraindications: Glaucoma, prostatic hypertrophy, benign bladder neck obstruction, hypersensitivity to chlordiazepoxide HCl and/or cimetidine Bromide.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants, and against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Physical and psychological dependence rarely reported on recommended doses, but use caution in administering Librax® (chlordiazepoxide HCl, Roche) to known addicts.

tion-prone individuals or those who might increase dosage, withdrawal symptoms (including convulsions) reported following discontinuation of the drug.

Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy. Advise patients to discuss therapy if they intend to or do become pregnant.

As with all anticholinergics, inhibition of lactation may occur.

Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules/day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such as MAO inhibitors, phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions reported in psychiatric patients. Employ usual precautions in treating anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation reported very rarely in patients receiving the drug.

and oral anticoagulants; causal relationship not established.

Adverse Reactions: No side effects or manifestations not seen with either compound alone reported with Librax. When chlordiazepoxide HCl is used alone, drowsiness, ataxia, confusion may occur, especially in elderly and debilitated, avoidable in most cases by proper dosage adjustment, but also occasionally observed at lower dosage ranges. Syncope reported in a few instances. Also encountered: isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent, generally controlled with dosage reduction, changes in EEG patterns may appear during and after treatment, blood dyscrasias (including agranulocytosis), jaundice, hepatic dysfunction reported occasionally with chlordiazepoxide HCl, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax typical of anticholinergic agents, i.e., dryness of mouth, blurring of vision, urinary hesitancy, constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.

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Ventricular hypertrophy	Hepatic disease
Hyperglycemia	Hyperuricemia
Diabetes mellitus	Gouty arthritis
Bronchial asthma	Sulfonamide hypersensitivity

Like any antihypertensive, use with caution in severe coronary insufficiency, recent myocardial infarction, cerebrovascular disease or chronic renal failure.

work/play—normal hemodynamic responses to exercise maintained.

love—low incidence of impotence and/or loss of libido:
2.8% in 1,923 patients studied.¹

cardiac output—tends to return to control values during long-term therapy.

blood flow—preserved in kidney.

No Single Advantage Determines Drug Choice.

Other factors must include:

The drug's effectiveness in a given patient, its side effects, warnings, precautions, tolerance, etc. A rational therapeutic choice depends on a careful assessment of all such factors.

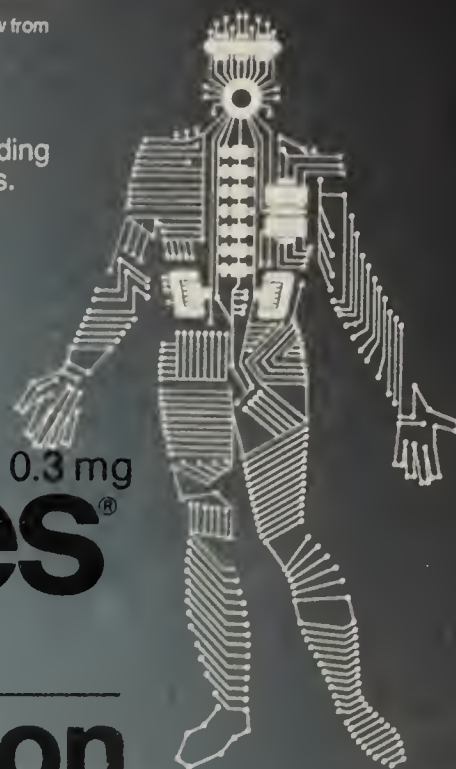
*Central alpha-adrenergic stimulation decreases sympathetic outflow from the brain, as shown in animal studies.

† Data on file at Boehringer Ingelheim Ltd.

Please see last page for brief summary, including warnings, precautions, and adverse reactions.

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(clonidine HCl)
Hypertension

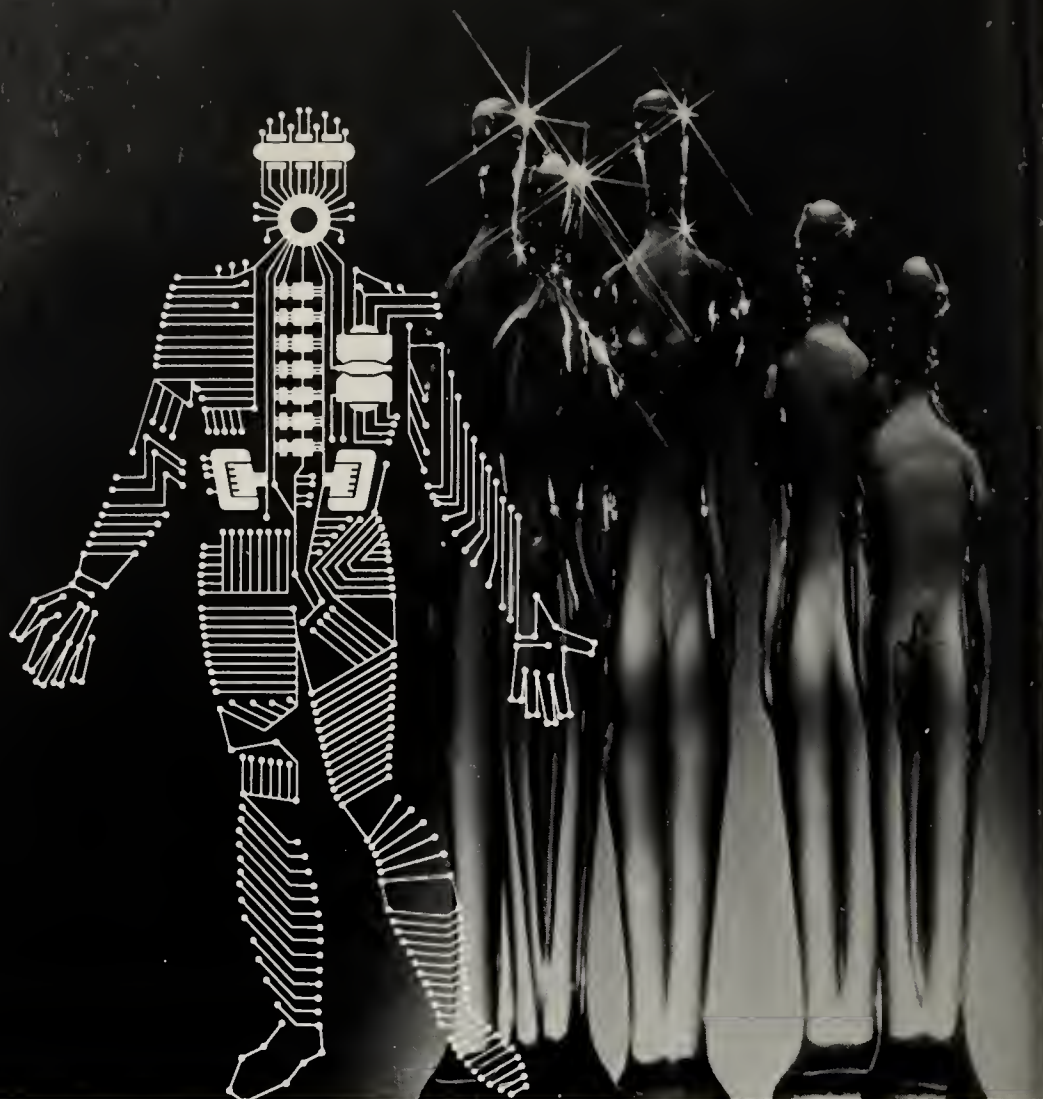




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Hypertension



- No contraindications.
- Effective in all degrees of hypertension. It is mild to moderate in potency.
- Low incidence of depression, impotence, orthostatic hypotension—no fatal hepatotoxicity.
- Preserves kidney blood flow.

Most common side effects are dry mouth, drowsiness, and sedation which generally tend to diminish with time.

Catapres®
(clonidine hydrochloride)
Tablets of 0.1, 0.2, 0.3 mg

Indication: The drug is indicated in the treatment of hypertension. As an anti-hypertensive drug, Catapres (clonidine hydrochloride) is mild to moderate in potency. It may be employed in a general treatment program with a diuretic and/or other antihypertensive agents as needed for proper patient response.

Warnings: Tolerance may develop in some patients necessitating a reevaluation of therapy.

Usage in Pregnancy: In view of embryotoxic findings in animals, and since information on possible adverse effects in pregnant women is limited to uncontrolled clinical data, the drug is not recommended in women who are or may become pregnant unless the potential benefits outweigh the potential risk to mother and fetus.

Usage in Children: No clinical experience is available with the use of Catapres (clonidine hydrochloride) in children.

Precautions: When discontinuing Catapres (clonidine hydrochloride), reduce the dose gradually over 2 to 4 days to avoid a possible rapid rise in blood pressure and associated subjective symptoms such as nervousness, agitation, and headache. Patients should be instructed not to discontinue therapy without consulting their physician. Rare instances of hypertensive encephalopathy and death have been recorded after cessation of clonidine hydrochloride therapy. A causal relationship has not been established in these cases. It has been demonstrated that an excessive rise in blood pressure, should it occur, can be reversed by resumption of clonidine hydrochloride therapy or by intravenous phentolamine. Patients who engage in potentially hazardous activities, such as operating machinery or driving, should be advised of the sedative effect. This drug may enhance the CNS-depressive effects of alcohol, barbiturates and other sedatives. Like any other agent lowering blood pressure, clonidine hydrochloride should be used with caution in patients with severe coronary insufficiency, recent myocardial infarction, cerebrovascular disease or chronic renal failure.

As an integral part of their overall long-term care, patients treated with Catapres (clonidine hydrochloride) should receive periodic eye examinations. While, except for some dryness of the eyes, no drug-related abnormal ophthalmologic findings have been recorded with Catapres (clonidine hydrochloride), in several studies the drug produced a dose-dependent increase in the incidence and severity of

The usual starting dose of Catapres is 0.1 mg at breakfast and 0.1 mg at bedtime. Some patients may benefit from a starting dose of 0.1 mg at bedtime.

Usual daily dose range—0.2—0.8 mg

Maximum daily dose—2.4 mg

Doses as high as this have rarely been employed.

For optimal results, the dose of Catapres must be adjusted according to the patient's individual blood pressure response.

spontaneously occurring retinal degeneration in albino rats treated for 6 months or longer.

Adverse Reactions: The most common reactions are dry mouth, drowsiness and sedation. Constipation, dizziness, headache, and fatigue have been reported. Generally these effects tend to diminish with continued therapy. The following reactions have been associated with the drug, some of them rarely. (In some instances an exact causal relationship has not been established.) These include: Anorexia, malaise, nausea, vomiting, parotid pain, mild transient abnormalities in liver function tests; one report of possible drug-induced hepatitis without icterus and hyperbilirubinemia in a patient receiving clonidine hydrochloride, chloralhydrate and papaverine hydrochloride. Weight gain, transient elevation of blood glucose, or serum creatine phosphokinase; congestive heart failure, Raynaud's phenomenon; vivid dreams or nightmares, insomnia, other behavioral changes, nervousness, restlessness, anxiety and mental depression. Also rash, angioneurotic edema, hives, urticaria, thinning of the hair, pruritus not associated with a rash, impotence, urinary retention, increased sensitivity to alcohol, dryness itching or burning of the eyes, dryness of the nasal mucosa, pallor, gynecomastia, weakly positive Coombs' test, asymptomatic electrocardiographic abnormalities manifested as Wenckebach period or ventricular trigeminy.

Overdosage: Profound hypotension, weakness, somnolence, diminished or absent reflexes and vomiting followed the accidental ingestion of Catapres (clonidine hydrochloride) by several children from 19 months to 5 years of age. Gastric lavage and administration of an analeptic and vasopressor led to complete recovery within 24 hours. Tolazoline in intravenous doses of 10 mg at 30-minute intervals usually abolishes all effects of Catapres, (clonidine hydrochloride) overdosage.

How Supplied: Catapres, brand of clonidine hydrochloride, is available as 0.1 mg (tan) and 0.2 mg (orange) oval, single-scored tablets in bottles of 100 and 1000. Also available as 0.3 mg (peach) oval, single-scored tablets in bottles of 100.

For complete details, please see full prescribing information.

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Physicians affiliating with Michigan HMOs generally report favorable experiences

By Dwight Angell, Special to Michigan Medicine

Still in their teething stage, health maintenance organizations (HMO) are becoming a fact of life in the Michigan health care system.

HMOs once were supported almost exclusively by government monies and manpower, but private insurance carriers now are jumping at the chance to own and operate them. Example: Michigan Blue Cross-Blue Shield's purchase of Lansing's Health Central.

Physicians are meeting throughout the state to discuss formation of their own HMOs. Some are only at the talking stage; others have translated talk into quick action, as in the case of physicians in Oakland County who formed the Michigan Master Health Plan.

HMO advantages

But HMOs remain controversial and debatable among MDs. We talked with some recently — physicians who have been associated with established HMOs. Their impressions of the HMO experience were, overall, quite favorable. We thought other physicians in the state might be interested.

Complaints were mostly about specific policies of a particular HMO, not the philosophy behind the HMOs. The physicians interviewed all endorsed that philosophy: high regard for the patient's health, less hospitalization for the patient, and a belief in the preventive approach to health care.

H. Richard Henderson, MD, Warren, of Group Health Plan of Southeast Michigan, a full-time internist and formerly GHPSEM medical director, says the major reason he joined the HMO was the capitation concept: that a member pays a set fee per month and all services are covered. "And since office visits are covered, you can see patients in the

office and order lab tests and not feel that you are taking money out of their pockets."

There are more pragmatic reasons for a physician to join an HMO. Richard O. Brown, MD, Detroit, ophthalmologist with Michigan HMO Plans, an independent practice association model HMO, cites the major reason for his joining an HMO was to increase his cash flow. The physician is paid by the HMO monthly. He had had problems with payments from government programs, especially Medicaid, where he says, "They slow-pay you, they don't pay you, they underpay you."



Robert J. Solomon, MD, an internist with Associated Physicians, a group of 27 doctors in Taylor, linked up with the Independence Health Plan about 18 months ago. About 10 percent of the patients his group sees are with the HMO. The smoother cash flow situation, he says, was one reason for joining.

Other reasons for joining an HMO include simply testing out the HMO experience on a trial basis; that the government was pushing HMOs as the wave of the future and one had better ride the crest; or because the physician had worked in an HMO-like community health center in the

HMOs/continued

60's and had enjoyed the experience.

HMO disadvantages

The major argument heard publicly against HMOs is that they don't always offer the best medical care; that there is a disposition to cut back on services for the patient in order to save money.

Says Doctor Solomon: "That's a bunch of malarkey. If you look at hospital days per 1,000 patients for HMOs and for private insurance companies, the cost savings allows you to do anything you want to do with patients. Now if you are going to say that by not admitting patients to hospitals you are neglecting them, I will fight you tooth and nail because we are following the same pattern of hospitalization as we are for our fee-for-service patients."

Others agreed with him; all had faith in the competence of their fellow HMO physicians and believe that patients are getting as good and probably better health care with HMOs than are patients on a fee-for-service basis. Says Doctor Solomon: "With HMO you can monitor the patient more closely. That is too hard to do with the fee-for-service patient because it costs them money. In the HMO the patient doesn't have to bear the out-of-pocket expenses."

The list of advantages given by the physicians for their being with an HMO were very wide-ranging.

William G. Bentley, MD, an obstetrician-gynecologist at Comprehensive Health Services of Detroit, likes the HMO setting "because you can better pinpoint where your health dollar goes."

Geoffrey Linz, MD, Lansing, an internist at Health Central for the last year, enjoys the experience of working side by side, literally, with other good physicians. He also has been allowed the opportunity to work on the administrative aspects of the organization.

But the other side of the coin also was expressed by physicians. Doctor Linz felt the loss of a certain amount of freedom in the staff practice at Health Central. For example, he said, referrals are usually OK'd by the non-medical administration rather than by a physician.

Several doctors mentioned that they do not have enough, if any, say in the planning and direction of the HMO organization. In Doctor Bentley's HMO, a group model, physicians contract their services with the HMO organization on an annual basis. The problem, he says, is that the group has to project each and all expenses before they negotiate with the organization. "And if you project wrong, you lose."

Doctor Solomon found that the greatest disadvantage for him and his group was that some patients are over-utilizers. It is only through re-education of the patient that the problem is rectified.

Patients adapt

But most of the physicians didn't have any real complaints about patients. They found that patients in time come to agree with the HMO philosophy. For example, Doctor Bentley deals primarily with Medicaid patients. Over the years, he says, the patients' acceptance of the HMO has increased tremendously.

"In the past, they had the feelings of being exploited for educational purposes. But in the last few years they have learned that their physician and the organization want to keep them healthy."

One Michigan physician, who is not with an HMO but who did a short stint in his residency program with the Kaiser-Permanente group, is Alan A. Halpern, MD, of Kalamazoo. The Kaiser-Permanente group is the oldest and largest HMO in the country and is located in California.

Doctor Halpern, an orthopedic surgeon, worked in an HMO hospital in Santa Clara, and came away seeing both pluses and minuses in the system. He found the quality of medicine to be good. He believes such a system is good for certain types of individuals and families (families with lots of children and with limited incomes). But he saw abuses by the patients.

For example, on Sunday evenings there developed a pattern of a quiet time and then suddenly a busy time in the emergency room. After several months the staff figured out the problem. The quiet time corresponded to the TV showing of "Kojak." Only when the program was finished did the patients come to the ER for medical care.

Of the doctors he worked with, most were happy at the HMO, says Doctor Halpern.

"The system attracted a certain type of physician. It's the type of physician who wants a fairly regular life — 9 to 5, a job with very predictable call schedules. It's a very controlled life style. You know basically how busy you are going to be. That's very appealing to some people.

"It's a self-selection process. By and large, the physicians are happy because that's what they have chosen."

Asked if he would join an HMO, he said he might if it wasn't large and if it was an IPA model.

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Two Michigan groups — HAP and MMHP — study in contrasts among HMOs

By Shelton Reece, special to Michigan Medicine

Forecasters predict that health maintenance organizations will grow in number and sizes dramatically in the next few years. They foresee many US companies offering employees three health plan alternatives: one traditional fee-for-service health insurance policy, and two types of HMO's — the closed staff model, or the independent practice association variety. A key element in the crystal ball-gazing is the federal law passed in 1973 which requires all firms with 25 or more employees to offer membership in an HMO (where one is available).

While there are various HMOs in Michigan, two structural types currently available to many residents in Southeastern Michigan are Health Alliance Plan of Michigan and Michigan Master Health Plan.

HAP biggest

The biggest in the state, and approximately the 10th largest in the nation, is Health Alliance Plan (called HAP), which services Metropolitan Detroit. HAP is a non-profit, federally-qualified, group-association HMO with around 83,000 subscribers. About 420 physicians are affiliated at this time. Its headquarters are at 2850 W. Grand Blvd., Detroit.

HAP is the outgrowth of prepaid group practice, Community Health Association, which dates back 23 years. The Community Health Association became the Metro Health Plan then, and metamorphosed into HAP. HAP links the two Metropolitan Hospitals and their five Health Centers, which originally served the Metro Health Plan, with Henry Ford Hospital and its three outpatient care centers. Together they provide prepaid health care.

About 40 percent of HAP's subscribers are automotive company employees, but its services are an option at approximately 450 companies, or organizations, of various sizes. HAP offers employee groups four different programs (which differ primar-



ily in service fees charged to subscribers) and, unlike some HMOs, has an individual program for persons or families who are not affiliated with a business concern. The five programs vary in coverage as do amounts that subscribers are charged for outpatient services.

The leading indicator of an HMO's effective control of utilization is, indeed, the rate of inpatient hospital care. During the 1978-79 year, HAP achieved a hospital utilization rate of 441 days of inpatient care per 1,000 members for those under age 65.

"This," according to HAP President James Walworth, "is approximately one-half the utilization rate reported for the past several years for Michigan's entire population. HAP achieved, in the under 65-years-old population, an annual hospital admission rate of 66 per 1,000 members. This means that the average HAP member will require hospital care only about once in 12 years."

In a group HMO such as HAP,

subscribers select the outpatient facility of their choice, usually the one nearest their home, then choose a physician who practices at that facility, as their personal physician. Members are free to change doctors or facilities within the plan, if they so desire.

That HAP is popular is shown by the fact that in 1978 the Metro Health Plan had a 73,000 enrollment. By June, 1979, it had grown to nearly 79,000. HAP membership now stands at 83,000. Walworth predicts that the HMO will grow about 10 percent in the next 12 months, in spite of economic conditions in Detroit.

As anticipated, HAP's largest membership growth has been among young people with growing families. Subscribers under family contracts grew in number by nearly 11 percent during the year, or nearly twice as fast as single and two-person contracts. Only about five percent of HAP's members are enrolled in the individual program.

HAP's family coverage includes

HMOs/continued

the spouse and all eligible single dependent children up to the age of 19 who live at home or who are students, or single dependent children of any age who are totally and permanently disabled. Coverage for single dependents to age 25 is available at additional cost under the Young Adult Rider. Also, when authorized by an employer, over-age-65 coverage is available to parents and grandparents of a HAP member or spouse, not necessarily living with or dependent on the member. Coverage is available also to dependents (for income tax purposes) who live with a member, but who are not necessarily related to the member, and, to those who have Medicare A and B.

Oakland MDs

Michigan Master Health Plan is a non-profit, state-licensed independent practice association, which is neither federally qualified nor funded. Enrollment is open to employee groups only. No provisions for individual enrollees are available.

This HMO was founded in 1979, by 47 Oakland County physicians.

Physician contracts with MMHP are arranged through a physician-owned corporation known as Michigan/Oakland Physicians Corp., PC. That corporation has a 20-year agreement with MMHP to provide it with the services of physicians.

MMHP's administration, marketing, and computerized claims processing are handled by Medserco, Inc. (a St. Louis, Missouri based firm) from the Plan's headquarters at 140 S. Saginaw Street, Pontiac.

As an independent practice association, Master Health Plan offers subscribers a comprehensive set of prepaid health services which emphasize preventive and outpatient care. It provides full coverage for a wide spectrum of services including acute, preventive, diagnostic, outpatient and inpatient care.

Subscribers may select any physician who affiliates with the Plan regardless of specialty or place of practice. Of course, they also may be admitted to hospitals where their doctor is a staff member — or, in case of an emergency, will be covered by this plan wherever they happen to be. However, MMHP now has spe-

cific in-patient agreements with Pontiac General, Crittenton, St. Joseph's Mercy, Pontiac, Providence, and Wheelock (in Genesee County) hospitals. The Plan accommodates all types of medical practices whether solo, small practice, or large multi-specialty groups.

All Oakland County-area physicians have the opportunity to become affiliated and about 600 already have done so. Physicians who affiliate are reimbursed for each professional service rendered through the fee-for-service concept and each assumes financial responsibility for a portion of the Plan; i.e., each participates in any surplus/deficit.

During every 12-month period, each is reimbursed at a rate of 90 percent of his prefilled guaranteed fees (guaranteed for one year). At year's end, the 10 percent of charges that were withheld and those which have not been used, are distributed to affiliated physicians. Additionally, any year-end surplus may be distributed to them. However, should a deficit occur, the deficiency is shared by all affiliates. The financial responsibility of an individual doctor to the Plan reflects the ratio of professional service payments made to him compared to the total professional service payments made to all affiliated physicians.

According to Billy Ben Baumann, MD, one of MMHP's founders, "Our Plan embodies four major concepts: cost containment, quality assessment, comprehensive benefits, and computerized administration.

While space doesn't allow a full description of each of those concepts, a brief idea of the Plan's cost containment activities might be useful.

Cost containment is directed at three major areas:

(1) Utilization of services. In this category, the Plan has a review process administered by doctors to assess the appropriateness of hospital admissions and length of confinements. The Plan conducts preadmission testing, designed to eliminate 'diagnostic only' hospital admissions and unnecessary duplication of such testing. . . The Plan provides patient education, a formal program of continuing education for physicians and patients, who are informed, for instance, of their role in self-care and control of costs. . . And there is am-

bulatory peer review, whereby physicians assess the quality of care rendered by every affiliate.

(2) Fees and charges.

Through a physician committee, MMHP reviews the fees and charges individually submitted by each affiliate. Charging habits also are monitored.

(3) Administration.

Payment of fees is largely computerized, allowing for on-line, real-time computerization which eliminates the need for claim forms and patient billing. This also permits remote computer terminals to be placed in physician offices and hospitals when cost effective."

"Hospital costs have risen at least two times more than the overall cost of living in most of the past 10 years," acknowledges Doctor Baumann. "Those costs now represent the largest component of health insurance premiums.

"There is great potential to save considerable amounts in the health care system simply by controlling unnecessary hospital utilization," he continues. "For example, the elimination of a single day from the average length of a hospital stay can save the nation over five billion dollars annually, or about three percent of insurance claim dollars.

"Multiple alternatives are being proposed to our existing health care system," he says. "Many of those proposals are repugnant to patients and physicians alike.

"We, of the Michigan Master Health Plan, believe HMOs such as ours can be the answer to a majority of the present health care system's weaknesses. This type of HMO not only preserves the traditional essentials of fee-for-service practice, but also allows for the free selection of physicians by patients.

"The success of our plan, and others like it, could go far toward inhibiting further government incursion into the private practice of medicine."

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VIEWS

Valid health comparisons cannot be made simply on basis of age

By Frederick C. Swartz, MD, Lansing

Michigan Medicine recently sent national expert on aging, Frederick C. Swartz, MD, FACP, Lansing, to cover a unique seminar on "Clinical Geropsychopharmacology." At the former Upjohn family estate, Brook Lodge, near Augusta, the two-and-a-half-day meeting brought together outstanding psychiatrists from across the country for open discussions on psychiatric and drug treatments of the elderly.

There was no prearranged program, and no speakers were scheduled. The group decided its format on arrival the first evening of the meeting.

The following are Doctor Swartz's observations:

Items to be considered in prescribing for the older patient according to the conference participants, are as follows:

Has the patient the mental competence to understand and follow directions?

Are pills or capsules a problem as compared with the use of liquid medications?

Pediatric caps on packages pose too much of a problem for oldsters. The physician must be sure the patient can read and understand the instructions, and this implies legibility of all written instructions. One must consult a relative regarding the ability of the patient to take medication from the standpoint of proper motivation.

Changing from generic to brand-name products by the pharmacy may cause a mix-up and frequently leads to duplication of medications. To be sure that the patient and physician are talking about the same medication, the MD must ask the older patient to bring in all the medication he or she is taking, including prescribed vitamins and over-the-counter drugs.

Doctor Swartz is an internist and former chairman of the MSMS Committee on Aging.

Since certain drugs or drug combinations cause orthostatic hypotension in oldsters, be sure to check the blood pressure while the patient is seated, and also while he is standing.

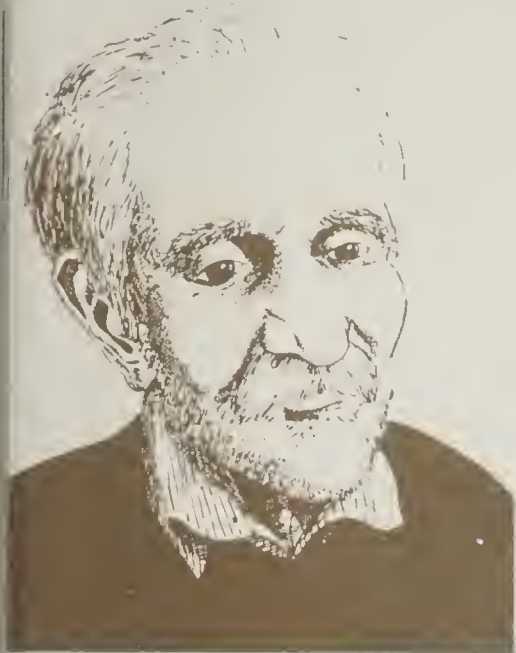
A spirited presentation of electric convulsive therapy indicated that this is one endeavor that seems to pay off better in the older patient. It was carefully pointed out that today's ECT programs are quite different from earlier ECT programs, and the present methods of treatment have tended to minimize the detrimental side effects. The present procedure consists in the unilateral placement of the electrodes, the use of adequate anesthesia, preferably of the phenobarbital type, and the positive pressure oxygenation. It was suggested that ECT should be considered earlier in the course of disease, and not as a treatment offered after other methods have failed. ECT was also listed as having produced some remarkable changes in the very late stages of Parkinson's disease.

Sleep disorders of the oldster were discussed. The REM rebound formerly reported as occurring with the use of phenobarbitols was not substantiated. It was suggested that when necessary, phenobarbital or chloralhydrate are good drugs to apply in these circumstances, and that they usually are less expensive than the newer hypnotic agents.

A critical analysis of the entire program brings out the bias of the reporter, who has in the past been a member of the Committee on Aging for the American Medical Association, and whose practice is largely made up of older patients.

At no time during the discussion did anyone define aging. That was in spite of the fact that everyone knows some people in their 50's who present many characteristics usually associated with advanced years, and others who, in their 80's, present a picture of a younger individual.

The usual paper presented in



Blue Pencil sketch.

his conference began with findings observed in a group of college students. These people were all healthy enough to be going to college, and weren't old enough to have developed the ravages of bad habits or chronic disease. These persons were compared with the older individual on the basis of numbers only.

The age of the older individual varied from paper to paper. In one, the dividing line was 40 years, in another, 55, in others, 65. Then, as sort of an after-thought, someone mentioned the "older oldster."

What I am trying to point out, is that comparing the younger age group with the oldster, is a precarious, uncertain venture, because what one sees in the older individual is not necessarily the result of age. It is well known that heavy cigarette smokers and alcohol users and the very obese do not have the same physiologic reactions of the young college student, nor of the non-smoking, non-alcoholic, non-obese oldster. The impact of any chronic illness or defect is going to have its effect on the physiology and the psychology of the older individual, so that any comparison cannot be regarded as etiologically relating to the age of the patient alone.

Basically there are essentially no disease entities that result from the passage of time. Disease entities seen in older individuals are the diseases of childhood and young adulthood which have continued. In other words, the impact of time alone produces not provable change in the individual. The older individual dis-

plays the impact of environment on his hereditary package and his reaction to this stress.

Woodruff and Metalnikoff state, "The alive cell in favorable conditions for its existence divides and multiplies itself indefinitely. This energy of multiplication does not lessen when time goes by, but it remains approximately at the same level."

From the famous experiences of Carrel, we have the statement, "When the composition of the medium is maintained constant, cellular colonies remain indefinitely in the state of activity."

Kullok and Kullok and Mayer say, "If we observe senescence in these tissues, it will always be due to the external medium in which their embryonic cells lived."

From the Lobund Laboratories of the University of Notre Dame, where experiments in germ-free rats have been conducted for a number of years, we have the following:

"Since 1964, 78 germ-free Wistar rats aged over 24 months, have been killed for examination. They were significantly free of specific hallmark lesions of aging which have been reported in conventional rats, consisting of nephrosis, periarteritis, degeneration of myocardial and striated muscle."

In conversation with Morris Pollard, MD, while writing this report, this writer learned the experiment with germ-free rats has now progressed to the point that the rats are living up to 47 months, and presenting the same results so far. This means they have practically doubled their life span without the passage of time having made any contribution usually associated with the so-called aging process.

"Senescence appears to be a problem involving the environment," the Lobund Laboratories report. "In

It seems obvious that the psychiatrist, like the blind man examining the elephant, sees the animal from a somewhat different viewpoint than the average primary physician. It is hard to picture any cohort of oldsters who have been exposed to the environmental effects of tobacco and alcohol use, overweight and chronic disease who could, in any way, make valid comparisons on a simple basis of age.

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Laughter keeps Bob Hope young

By Willah Weddon, special to Michigan Medicine



"Old Ski Nose" answers reporter's questions and signs autographs at Jackson, Michigan, airport this summer.

"While in Moscow, I plan to visit Lenin's tomb and get the name of his make-up man," Bob Hope quipped on a nationally televised program. Those who have seen him recently, in person, can attest there is no need for him to make the trip.

Hope played the Jackson County Fair this summer and looked great. He later responded to *Michigan Medicine's* request for his secrets to staying young and healthy.

Hope was born in London, England in 1903 and is 77 years of age. According to his press agent, Ward Grant, he's only 53. "He'd better say that, or he doesn't eat," Hope jokes. But Norma Brown, a secretary of Hope's, adds on her own, "He is a man who has truly captured the secret of youthful living."

Part of his youthful appearance is due to the fact that he walks erect and easily, apparently in good physi-

cal condition and well "Shaped up for Life." Part of it is also due to the genuine expression of friendliness in his eyes. He likes people. But there is more.

"I think he just keeps moving and that keeps him young," says Herman Gumper, Jackson County Fair manager. "He hasn't changed a bit in the two years since he was here in 1978." (At \$58,000 plus expenses, for two appearances in one evening, it might be worth the effort.)

Hope's secrets

To what does he attribute his good health? Exercise, keeping active and involved with people, and watching his diet. To wit, he brought his golf clubs with him, had returned to Jackson because he liked to keep active and liked the people there, "a great audience," and added that if he didn't watch his diet, "Dolores does."

So what is that extra ingredient keeping Hope so young and vital?

"Being able to laugh and to make others laugh," is his explanation.

Laughter provides an "instant vacation" he contends. He adds that fun and laughter are the most wonderful tonics in the world. To illustrate his philosophy, he recalled how Presidents of the United States have resorted to humor when under pressure to keep their perspective and to relax from the burdens of their office.

In his own story, "Laugh a Little — Live a Lot," which appeared in *Physical Fitness Magazine*, he related:

Franklin D. Roosevelt, for example, had a great sense of humor. During World War II when things were pretty grim, I quipped to an audience that included him: "World strategy means where and when will we attack the enemy and what'll we do with Eleanor?"

FDR banged his hand on the table and roared. "That was a very funny joke about Eleanor," he told me later. "I'm going to tell it to her

the next time I write her."

Dwight Eisenhower also appreciated a good joke, according to Hope, who poked fun at his frequent travels. "Once he rushed to the airport and when the pilot asked, 'Where to?' Ike replied, 'Anyplace. We've got troubles all over.'"

Gerald R. Ford's wandering golf balls provided great grist for Hope's monologues. While in Jackson he referred to the Bob Hope Desert Classic saying, "Jerry Ford plays in our tournament. People always turn out to see an accident."

And when commenting on the political scene, Hope's assessment of Ford's earlier consideration as Ronald Reagan's vice-presidential running mate was, "It would be silly to see Reagan sleeping in a pup tent in the rose garden."

Scientists confirm

Joy and celebration are a vital part of human nature, Hope contends. He points to children who have fun and laugh naturally.

"When I went to school, learning was a very serious matter. The questions were hard. But fortunately, praying was still legal."

Teachers have discovered that children can absorb more knowledge when learning is fun, he pointed out, adding that Captain Kangaroo could have told them this in the first place.

It distresses him that along the way many adults lose the knack of applying humor to their daily lives. In his opinion laughing or creating laughter "is as important as any medicine . . . and it costs absolutely nothing."

Hope, who has entertained GIs in three world wars, has seen the healing power of laughter and is still seeing it in hospitals he visits. He is pleased that scientists have confirmed his belief that "having fun . . . feeling happy or joyous . . . have a measurable effect on our health, well-being and even how long we live."

Coming back to his own age, he applies the same philosophy. "When asked if I've had my face lifted," he said, "I reply that I have my body sand-blasted every year."

This sense of humor may not ensure eternal life, but there's no question but Bob Hope has already established his own bit of immortality.

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Contraindications: Further use in anuria, progressive renal or hepatic dysfunction, hyperkalemia. Pre-existing elevated serum potassium. Hypersensitivity to either component or other sulfonamide-derived drugs.

Warnings: Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired. If supplementary potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with cardiac irregularities. It is more likely in the severely ill, with urine volume less than one liter/day, the elderly and diabetics with suspected or confirmed renal insufficiency. Periodically, serum K⁺ levels should be determined. If hyperkalemia develops, substitute a thiazide alone, restrict K⁺ intake. **Associated widened QRS complex or arrhythmia requires prompt additional therapy.** Thiazides cross the placental barrier and appear in cord blood. Use in pregnancy requires weighing anticipated benefits against possible hazards, including fetal or neonatal jaundice, throm-

bocytopenia, other adverse reactions seen in adults. Thiazides appear and triamterene may appear in breast milk. If their use is essential, the patient should stop nursing. Adequate information on use in children is not available. Sensitivity reactions may occur in patients with or without a history of allergy or bronchial asthma. Possible exacerbation or activation of systemic lupus erythematosus has been reported with thiazide diuretics.

Precautions: Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics or those with suspected or confirmed renal insufficiency. Watch for signs of impending coma in severe liver disease. If spironolactone is used concomitantly, determine serum K⁺ frequently, both can cause K⁺ retention and elevated serum K⁺. Two deaths have been reported with such concomitant therapy (in one, recommended dosage was exceeded, in the other serum electrolytes were not properly monitored). Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving triamterene, and leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with thiazides. Triamterene is a weak folic acid antagonist. Do periodic blood studies in cirrhotics with splenomegaly. Antihypertensive effect may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with

possible metabolic acidosis. 'Dyazide' interferes with fluorescent measurement of quinidine. Hypokalemia, although uncommon, has been reported. Corrective measures should be instituted cautiously and serum potassium levels determined. Discontinue corrective measures and 'Dyazide' should laboratory values reveal elevated serum potassium. Chloride deficit may occur as well as dilutional hyponatremia. Serum PBI levels may decrease without signs of thyroid disturbance. Calcium excretion is decreased by thiazides. 'Dyazide' should be withdrawn before conducting tests for parathyroid function.

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WARNING: Because of the potential hazard of nephrotoxicity and ototoxicity due to neomycin, care should be exercised when using this product in treating extensive burns, trophic ulceration and other extensive conditions where absorption of neomycin is possible. In burns where more than 20 percent of the body surface is affected, especially if the patient has impaired renal function or is receiving other aminoglycoside antibiotics concurrently, not more than one application a day is recommended.

When using neomycin-containing products to control secondary infection in the chronic dermatoses, it should be borne in mind that the skin is more liable to become sensitized to many substances, including neomycin. The manifestation of sensitization to neomycin is usually a low grade reddening with swelling, dry scaling and itching; it may be manifest simply as a failure to heal. During long-term use of neomycin-containing products, periodic examination for such signs is advisable and the patient should be told to discontinue the product if they are observed. These symptoms regress quickly on withdrawing the medication. Neomycin-containing applications should be avoided for that patient thereafter.

PRECAUTIONS: As with other antibacterial preparations, prolonged use may result in overgrowth of non-susceptible organisms, including fungi. Appropriate measures should be taken if this occurs.

ADVERSE REACTIONS: Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of persons allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section). Complete literature available on request from Professional Services Dept. PML.



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"Smalltown:" A Case History of Physician Retentionitis

By Charles R. Downs, Special to Michigan Medicine

"This study of why 10 doctors left one small community in a short period of time is the first that we know of in Michigan," declares Herbert A. Auer, executive vice-president of the Michigan Health Council.

"Many communities contact the Michigan Health Council Physician Placement Service and want assistance in recruiting one or more physicians. We need more research to determine why physicians leave some communities to go to others," he continues.

The MHC is grateful, Mr. Auer stresses, that the Michigan State Medical Society was willing to fund this survey project. Mr. Auer adds that MHC is interested in finding several other communities willing to participate in such a project, so that additional research data can be obtained for further study.

This article, he points out, does not name the community in this survey because comments might be embarrassing to physicians in the town and to community leaders.

There is an old saying that "you can take a boy out of the country, but you can't take the country out of a boy."

That seems to be true for physicians as well as boys and for the city as well as the country, according to a recent MSMS and Michigan Health Council study made of moves in and out of a small Michigan city.

Of 10 doctors for whom data were available, seven were from urban areas and six returned to urban areas. Three were from rural areas and all of them moved to other small communities.

But the physicians did not directly cite town size as a reason for moving. Rather, the reasons given dealt with disappointments in professional structures and relationships and in the quality of the health care facilities.

However, it could be argued that such disappointments might reflect



personal perceptions of a community in which the extent and range of available colleagues and facilities are closely circumscribed. In other words, the city-reared physicians might have had higher expectations than their country cousins.

The research project reported here was conducted by Sharon Bommarito, who was graduated in June from the Michigan State University College of Urban Development. She was advised in the study by John Richards, chief, MSMS Bureau of Economics, and Herbert A. Auer, executive vice president of the Michigan Health Council.

The setting

The city studied, which will be known in this article as "Smalltown," has a population of 9,000.

White Protestants predominate and the average income is \$11,000. There is some industry in the town, but most people work in a larger city 20 miles away. That city also offers

larger hospitals and many specialists, as well as educational opportunities and cultural amenities not found in Smalltown.

Smalltown's hospital has less than 50 beds, including a small number of obstetric and pediatric beds. Most of its annual 2,400 admissions come from Smalltown and nearby communities.

Eight physicians have hospital privileges. This includes four full-time and one part-time physician with offices in Smalltown. Of these, four are MDs and one is a DO. Four practice in a well-equipped building next to the hospital.

The health planning board for the area thinks Smalltown needs at least three more physicians. The supply of physicians has been somewhat mercurial, ranging from a high of 14 physicians on the hospital staff in 1966 to a low of five (with three in Smalltown offices) in 1973.

In her study, Ms. Bommarito sent questionnaires to the 14 physicians



The opportunities of MSMS' new video taping and playback equipment are demonstrated to the new MSMS Committee on Medical Education Policy. From left, they are Richard W. Pomeroy, MD, Okemos; E. James Potchen, MD, East Lansing; Samuel M. McMahon, MD, Lansing; Carl F. Hammerstrom, MD, Marquette, and Charles C. Vincent, MD, Detroit, chairman. MSMS is using the TV equipment for educational and communications projects.

SMALLTOWN/continued

(10 MDs and four DOs) who left Smalltown between 1966 and 1979. Nine (eight MDs and one DO) responded fully. Two did not want to participate, one could not be located for a follow-up to the questionnaire, one is a missionary abroad and one is retired.

The doctors split about evenly in their opinions of educational opportunities and transportation services, but agreed that cultural opportunities were lacking.

However, there was consensus that on the whole, Smalltown was an acceptable place to work and raise a family.

Major dissatisfactions

The major expressed sources of dissatisfaction were the professional structure of the medical community, including relationships with established physicians, the hospital administration and the county medical society.

All of the doctors surveyed felt there was a genuine need for their services, but four said flatly that the established doctors were not encouraging because they feared loss of

profits. Eight said it was difficult to arrange off-duty coverage and six felt the difficulty was due to professional jealousies.

Ms. Bommarito points out in her survey that most of the doctors interviewed were in solo practice and that might have made it difficult to arrange coverage during off hours.

One of the urban-reared doctors was vitriolic in his denunciation of established physicians, using such expressions as "cutthroats" and "back stabbers."

All except one said they had to carry exceptionally heavy workloads in order to meet income expectations. Seven said their income increased substantially after they left Smalltown.

Eight of nine said the hospital administration was poor and six called it hostile to new doctors. And when asked how Smalltown could be made more attractive to doctors, they were virtually unanimous in calling for improved facilities.

Steps taken

Since the study was made last year, steps have been taken to correct major problems. The hospital is undergoing extensive renovation.

The hospital administration has been strengthened through a contractual arrangement with a larger hospital. And, a committee of hospital and community leaders has been organized to aggressively recruit new physicians.

But Ms. Bommarito notes that two major problems remain: lack of cooperation in the medical community and emphasis on solo practice.

"If Smalltown wishes to attract new practitioners, it is important to encourage professional support among the established doctors," she says. "This could take the form of more cooperative off-duty coverage. A logical extension of this cooperative effort would be for existing Smalltown doctors to open their practices to new physicians. The advantage would be two-fold: (1) new doctors would find it more economically feasible to join an existing practice, and (2) a group practice would enable doctors to arrange for better off-duty coverage, thus easing heavy workloads of solo practitioners.

"To conclude, good professional support is essential for maintaining successful and satisfying practices.

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NEWS

By Bonnie L. Groff, MSMS staff



Doctor Gregg



Doctor Krause



Doctor Penney



Doctor Young

Arthur F. Kohrman, MD, East Lansing, left his post as associate dean for educational programs in Michigan State University's College of Human Medicine to become a congressional fellow to advise on health policy in the Office of Technology Assessment. The OTA was created to anticipate and evaluate technological developments in such areas as energy, transportation, defense and health to help congress set public policy. . . . **John C. Peirce, MD**, Grand Rapids nephrologist, and **William Young, MD**, Holt, were appointed by Governor Milliken to the Chronic Disease Advisory Committee. The committee is to advise and assist the State Department of Public Health in carrying out programs related to prevention, control and treatment of chronic diseases. . . . **Cory E. Cookingham, MD**, Flint, is the new president of the Michigan Allergy Society. . . . The Educational Commission for Foreign Medical Graduates has named **Mohammed Akhter, MD**, Lansing, to a panel which will review applications for a program providing up to \$100,000 in grants-in-aid. The grants will go to not-for-profit agencies, organizations and institutions for projects that will improve the communications skills of FMGs; enhance FMGs' understanding of education, economics and the

political process in the US; improve the American peoples' understanding of FMGs' contribution to American medicine; sponsor research on the effects of availability of graduate medical programs in the US for FMGs. . . . **Gary E. Ruoff, MD**, Kalamazoo, was installed as president of the Michigan Academy of Family Physicians at that group's recent annual meeting. . . . New president-elect of the American Academy of Facial Plastic and Reconstructive Surgery is **Charles J. Krause, MD**, Ann Arbor. Chosen as new regional vice president is **Robert H. Mathog, MD**, Detroit. . . . Named physician of the year by the Michigan Academy of Family Practice is **Robert J. Toteff, MD**, Saginaw. The award is made not only on the basis of professional and academic excellence but also the physician's community involvement. . . . **Mahmud U. Syed, MD**, Detroit, was appointed director-medical staff for the Detroit Edison Company. Doctor Syed is responsible for the utility's medical operations located at all major company sites. . . . **Robert G. Songe, MD**, Dearborn, is among the five new members of the Editorial Consultant Panel for the AMA's Current Procedural Terminology. . . . **Hugh Deery, MD**, and **Jesus Garcia-Sevilla, MD**, both of Ann Arbor, have been named the first recipients of the John G. Searle Fellowship in clinical pharmacology for their work with antibiotics and infectious disease and with mental depression. . . . **Robert Gregg, MD**, Detroit, is chairman-elect of the Board of Trustees of the National Association of Children's Hospitals and Related Institutions. NACHRI is an association of 73 leading children's hospitals throughout the US and Canada. . . . **James Coleman, MD**, Detroit, will fill the vacant position of vice chairman of the Detroit-Wayne County EMS Council. . . . **Fazlolah Nickhah, MD**, Ypsilanti, attended the Olympic Games in Moscow. Doctor Nickhah, an official for the International Wrestling Federation, was prohibited by the US State Department from participating actively in the games but was not barred from traveling to the USSR.

. . . A new audiocassette program on nephrology available from the American Academy of Pediatrics features **William J. Oliver, MD**, Ann Arbor. . . . **Jack Penney, MD**, and **Anne Young, MD**, are co-directors of a clinic at the University of Michigan Hospital. They head the recently-established Movement Disorder Clinic, one of three sub-specialty clinics in the department of neurology. . . . A paper entitled "Exercise-Induced 201 Thallium Perfusion Defects without Coronary Artery Obstruction: Evaluation of the False-Positive." by **Melvyn Rubenfire, MD**, Detroit, was named one of the 14 top research papers by the Scientific Program Committee of the American College of Chest Physicians at its annual scientific assembly. . . . **William W. Moon, MD**, Harrietta, Health Officer/Medical Director of Western Michigan Associated Health Departments, was recently awarded the Distinguished Service Award from the Michigan Health Officer's Association. This award is given to a member who has made an outstanding contribution to public health through service to the region which assigned. . . . **Benjamin Blum, MD**, Petosky, was one of three senior citizens honored by the state Offices of Services to the Aging at the Michigan State Fair. . . . The Sept. 15 issue of *Medical Economics* contains an article by **Sander J. Breiner, MD**, Birmingham, entitled, "Lecturing in China isn't all Peking-duck soup."

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The hidden cost of "cheaper" generic drugs

Much of the enthusiasm for generic prescribing is based on a shortsighted view that fails to take such long-term issues into account. While cost is an important factor, pharmaceutical research, the quality of medicine, and future generations of patients must all be considered.

Settling for cheaper drugs today could deprive you and your patients of the drugs they may need tomorrow.



ROCHE

To encourage imitation is to discourage innovation

CATEGORY I COURSES

Michigan Medicine each month carries a list of opportunities in Michigan for doctors of medicine to obtain Category I credit toward meeting the requirements of Michigan law. Sponsors of Category I programs and courses in Michigan are invited to submit information for the monthly calendar.

Each listing below, of programs that carry at least 3 hours of Category I credit, indicates a contact person, so the physician can obtain details. Physicians with questions about accredited programs may phone MSMS Headquarters, 517/337-1351.

Date: Dec. 13, General Pathologic Problems Encountered in the Practice of Forensic Pathology. Location: Towsley Center, Ann Arbor. **Sponsor:** Michigan Society of Pathologists. **For:** Pathologists. **Contact:** T. A. Reyman, MD, Department of Pathology, Mt. Carmel Mercy Hospital, Detroit, 48235. **Approved for:** 3 hours of Category I Credit.

Date: Jan. 10, Rheumatology Update. Location: Traverse City Osteopathic Hospital. **Sponsor:** Department of Osteopathic Medicine, Michigan State University. **For:** All interested physicians. **Contact:** Sandy Kilbourn, Coordinator CME, 517/353-8822. **Approved for:** 6 hours of Category I Credit.

Date: Jan. 21, Current Advances in Hepatitis and Liver Diseases. Location: St. John Hospital, Detroit. **Sponsor:** St. John Hospital. **For:** All interested physicians. **Cost:** \$100. **Contact:** Ms. Linda Radu, Continuing Medical Education, 313/343-3877. **Approved for:** 8 hours of Category I Credit.

Date: Feb. 1-6, Midwinter Family Practice Update. Location: Boyne Highlands, Harbor Springs. **Sponsor:** U-M Office of CME. **For:** All

interested physicians. **Contact:** William R. Harlin, MD, Dept. of Postgraduate Medicine and Health Professions Education, Towsley Center, U-M, Ann Arbor, 48109. **Approved for:** 22 hours of Category I Credit.

Date: Feb. 7, Rheumatology Update. Location: Saginaw Osteopathic Hospital. **Sponsor:** Department of Osteopathic Medicine, Michigan State University. **For:** All interested physicians. **Contact:** Sandy Kilbourn, Coordinator CME, 517/353-8822. **Approved for:** 6 hours of Category I Credit.

Date: Feb. 14, A Practical Endocrinologic Approach for the Diagnosis of Thyroid and Adrenal Disorders. Location: Henry Ford Hospital, Detroit. **Sponsor:** Michigan Society of Pathologists. **For:** All interested physicians. **Contact:** T. A. Reyman, MD, Department of Pathology, Mt. Carmel Mercy Hospital, Detroit, MI 48236. **Approved for:** 3 hours of Category I Credit.

Date: Feb. 18-19, Problems & Perspectives in Pulmonary Infections. Location: Boyne Highlands. **Sponsor:** Henry Ford Hospital. **For:** All interested physicians. **Contact:** Office of Medical Education, Henry Ford Hospital, 2799 W.

Grand Blvd., Detroit, 48202, 313/876-1463. **Approved for:** 7 hours of Category I Credit.

Date: Feb. 20-22, Practical Otolaryngology. Location: Dearborn Inn, Dearborn. **Sponsor:** Wayne State University Office of CME. **For:** All interested physicians. **Contact:** Ms. Anita Tompkins, 313/577-1180. **Approved for:** 12 hours of Category I Credit.

Date: Feb. 21, Rheumatology Update. Location: Muskegon Osteopathic Hospital. **Sponsor:** Department of Osteopathic Medicine, Michigan State University. **For:** All interested physicians. **Contact:** Sandy Kilbourn, Coordinator CME, 517/353-8822. **Approved For:** 6 hours of Category I Credit.

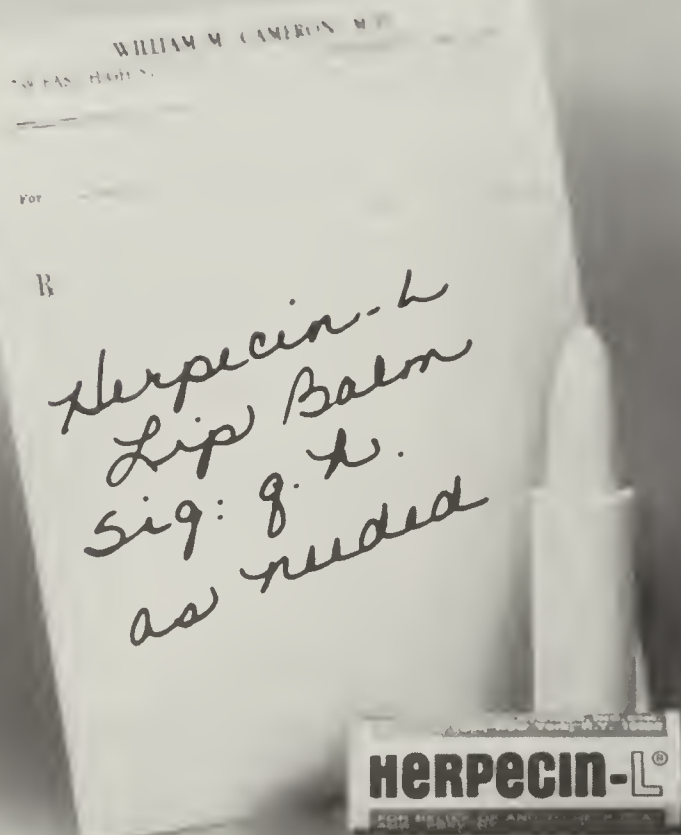
Date: Feb. 23-Mar. 2, St. Thomas Adventure. Location: St. Thomas, Virgin Islands. **Sponsor:** Michigan State University College of Osteopathic Medicine Alumni and the MSU College of Osteopathic Medicine. **For:** All interested physicians. **Contact:** Sandy Kilbourn, Coordinator CME, 517/353-8822. **Approved for:** 20 hours of Category I Credit.

Date: March 4, Adolescent Gynecology and Obstetrics. Location: St. John Hospital, Detroit. **Sponsor:** St. John Hospital. **For:** All interested physicians. **Cost:** \$100. **Contact:** Ms. Linda Radu, Continuing Medical Education, 313/343-3877. **Approved for:** 8 hours of Category I Credit.

Date: Mar. 8, 3rd Annual Pain Conference, "Stress and Its Effect on Musculoskeletal Pain." Location: Kellogg Center, MSU, East Lansing. **Sponsor:** Michigan State University College of Osteopathic Medicine. **For:** All interested physicians. **Contact:** Sandy Kilbourn, Coordinator CME, 517/353-8822. **Approved for:** 7 hours of Category I Credit.

Date: Mar. 22, 4th Annual Pediatrics Confer-

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ence. Location: Kellogg Center, MSU, East Lansing. **Sponsor:** Department of Pediatrics, Michigan State University College of Osteopathic Medicine. **For:** All interested physicians. **Contact:** Sandy Kilbourn, Coordinator CME, 517/353-8822. **Approved for:** 7½ hours of Category I Credit.

Date: April 1-4, **Aesthetic and Reconstructive Surgery of the Head and Neck.** **Location:** Campus Inn, Ann Arbor. **Sponsor:** Department of Otolaryngology, University of Michigan Medical Center. **For:** All interested physicians. **Cost:** \$500. **Contact:** Shan R. Baker, MD, Dept. of Otolaryngology, University of Michigan Medical Center, Ann Arbor, 48109. **Approved for:** 28 hours of Category I Credit.

Date: April 11, **Breast Cancer.** **Location:** Kellogg Center, MSU, East Lansing. **Sponsor:** Michigan State University College of Osteopathic Medicine and College of Human Medicine. **For:** All interested physicians. **Contact:** Sandy Kilbourn, Coordinator CME, 517/353-8822. **Approved for:** 8 hours of Category I Credit.

Date: April 15, **Pediatric Seminar V.** **Location:** Saint John Hospital, Detroit. **Sponsor:** Saint John Hospital. **For:** All interested physicians. **Cost:** \$100. **Contact:** Ms. Linda Radu, Office of CME, Saint John Hospital, 22101 Moross Rd., Detroit, 48236. 313/343-4000. **Approved for:** 8 hours of Category I Credit.

Date: April 25-29, **Advanced Muscle Energy Tutorial.** **Location:** Kellogg Center, MSU, East Lansing. **Sponsor:** Michigan State University College of Osteopathic Medicine. **For:** All interested physicians. **Contact:** Sandy Kilbourn, Coordinator CME, 517/353-8822. **Approved for:** 40 hours of Category I Credit.

Date: May 14, **Major Problems in Adolescence.** **Location:** Kalamazoo Hilton. **Sponsor:** South-

western Michigan Area Health Education Center. **For:** All interested physicians. **Cost:** \$55. **Contact:** Charles L. Zeller, Jr., MD, SMAHEC, 252 East Lovell, Kalamazoo, 49007. **Approved for:** 7 hours of Category I Credit.

Date: May 16-18, **Michigan Dermatological Society Central States Meeting.** **Location:** University of Michigan, Ann Arbor. **Sponsor:** Michigan Dermatological Society. **For:** All dermatologists. **Contact:** Alejandro Morales, MD, 1015 Fernwood, Royal Oak, 48067. **Approved for:** 6 hours of Category I Credit.

Date: May 20, **Family Practice Update.** **Location:** Saint John Hospital, Detroit. **Sponsor:** Saint John Hospital. **For:** All interested physicians. **Cost:** \$100. **Contact:** Ms. Linda Radu, Continuing Medical Education, 313/343-3877. **Approved for:** 8 hours of Category I Credit.

Date: June 15-19, **Basic Principles of Manual Medicine.** **Location:** Kellogg Center, MSU, East Lansing. **Sponsor:** Michigan State University College of Osteopathic Medicine. **For:** All interested physicians. **Contact:** Sandy Kilbourn, Coordinator CME, 517/353-8822. **Approved for:** 40 hours of Category I Credit.

Date: June 19-21, **Michigan Dermatological Society Annual Meeting.** **Location:** Renaissance Center, Detroit. **Sponsor:** Michigan Dermatological Society. **For:** All interested dermatologists. **Contact:** Alejandro Morales, MD, 1015 Fernwood, Royal Oak, 48067. **Approved for:** 6 hours of Category I Credit.

Date: Aug. 18-21, **Michigan Health Officers Association Annual Meeting.** **Location:** Holiday Inn, Traverse City. **Sponsor:** Michigan Health Officers Association. **For:** All interested physicians and health officers. **Contact:** William W. Moon, MD, Box 43, Harrietta, 49638. **Approved for:** 5 hours of Category I Credit.

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MEETINGS

MSMS, AMA, MSMS/A and medical assistants

Jan. 4-7 — 7th AMA State Health Legislation Meeting, Sonesta Beach Hotel and Tennis Club, Key Biscayne, FL, contact: Department of State Legislation, AMA, 535 N. Dearborn St., Chicago, 60610.

Jan. 17-24 — MSMS/Intrav West Indies Air/Sea Cruise, contact: Marce-lynn Ireland, MSMS headquarters. 517/337-1351.

Jan. 21 — MSMS Council, MSMS headquarters, contact: Warren Try-loff, MSMS headquarters.

Jan. 24 — AMA 22nd National Con-ference on the Medical Aspects of Sports, Atlanta Hilton, contact: Jack Bell, AMA, 535 N. Dearborn, Chi-cago, 60610.

Jan. 24-26 — AMA Winter Scientific Meeting, Atlanta Hilton, contact: De-partment of Meeting Services, AMA, 535 N. Dearborn St., Chicago, 60610.

Jan. 26 — MSMS/A mid-year board meeting, MSMS headquarters, con-tact: Caroline Rich, MSMS headquar-ters.

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Jan. 31-Feb. 1 — Mid-Winter Semi-nar, State of Michigan Branch, American Association of Medical Assistants, Benton Harbor, contact: Caroline Rich, MSMS headquarters.

Feb. 10-11 — MSMS/Physician Serv-ice Group, Inc. Practice Management Seminar, Long's Convention Center, Lansing, contact: Meridith Fors, MSMS headquarters.

Feb. 12-13 — Practice Management Seminar, sponsored by MSMS/ Physician Service Group, Inc. Mich-igan Inn, Southfield, contact: Mere-dith Fors, MSMS headquarters.

Feb. 12-14 — 1981 AMA National Leadership Conference, Marriott Hotel, Chicago, contact: Linda Hud-son, AMA headquarters, 312/751-6716.

Feb. 20-Mar. 7 — MSMS/Intrav South African Adventure, contact: Marce-lynn Ireland, MSMS headquarters, 517/337-1351.

Mar. 11 — MSMS/A Legislative Day, Civic Center, Lansing, contact: Caroline Rich, MSMS headquarters.

Mar. 25-26 — MSMS Conference on Maternal and Perinatal Health, Hyatt Regency Dearborn, contact: Katie Brewbaker, MSMS headquarters.

Apr. 9 — MSMS Conference on Sports Medicine, Western Michigan University Student Center, Kala-mazoo, contact: Mert Scholten, MSMS headquarters.

Apr. 23-26 — State Convention, State of Michigan Branch, American As-sociation of Medical Assistants, Hil-ton, Lansing, contact: Caroline Rich, MSMS headquarters.

Apr. 27-29 — MSMS/A 55th Annual Convention, Marriott, Grand Rapids, contact: Caroline Rich, MSMS head-quarters.

May 1-3 — MSMS House of Dele-gates, Troy Hilton, contact: Rich-ard Campau, MSMS headquarters.

Other meetings

Jan. 16 — Annual Membership Meet-ing, Michigan Ophthalmological So-ciety. Wayne County Medical Soci-ety, Detroit, contact: Margot Sur-ridge, Executive Secretary, 313/839-3011.

Jan. 22 — Council Meeting, Michi-gan Psychiatric Society. Hyatt Re-gency Dearborn, contact: Helen

Schulte, MSMS headquarters.

Feb. 11 — Membership Meeting, Michigan Dermatological Society. Henry Ford Hospital, Detroit, con-tact: Alejandro Morales, MD, 1015 Fernwood, Royal Oak, 48067.

Feb. 26 — Council Meeting, Michi-gan Psychiatric Society. Marriott Inn, Ann Arbor, contact: Helen Schulte, MSMS headquarters.

Mar. 11 — Membership Meeting, Michigan Dermatological Society, Wayne State University, Detroit, con-tact: Alejandro Morales, MD, 1015 Fernwood, Royal Oak, 48067.

Apr. 30 — Annual Meeting, Michi-gan Society of Thoracic Surgeons. Hyatt Regency Dearborn, contact: Rodman E. Taber, MD, 30050 Hoover Road, Warren, 48093.

May 27-29 — Conference, Michigan Public Health Association. Location to be determined, contact: MPHA, 1407 S. Harrison, Suite 340, East Lansing, 48823.

July 29-30 — 24th Annual Congress of Delegates Meeting, Michigan Academy of Family Physicians. Holiday Inn, Traverse City, contact: Loretta Joyce, Executive Director, 416 N. Homer, Suite 107, Lansing, 48912.

Aug. 1-3 — 35th Annual Scientific Assembly, Michigan Academy of Family Physicians. Holiday Inn, Traverse City, contact: Loretta Joyce, Executive Director, 416 N. Homer, Suite 107, Lansing, 48912.



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Members of the Michigan State Medical Society join in welcoming the following new members into a progressive state medical organization. MSMS is dedicated to promoting the science and art of medicine, the protection of the public health, and the betterment of the medical profession. Each new member is encouraged to join with other MSMS members at both the local and state levels in achieving these goals.



Jody Lee Alexander, MD	OBG	Stephen H. Cruikshank, MD	OBG
3075 Clark Rd. #107 Ypsilanti, 48197		1900 Wealthy St., SE Grand Rapids, 49506	
Christian E. Allan, MD	OBG	Kuldip S. Deogun, MD	AN
314 Brown St. Mt. Pleasant, 48858		St. Joseph Mercy Hosp. Pontiac, 48053	
Richard J. Allen, MD	FP	John S. Dolbee, MD	PD
2110 N. Morson Saginaw, 48602		511 E. Minges Battle Creek, 49017	
Chitra D. Amladi, MD	IM	Piyush K. Desai, MD	AN
6767 W. Outer Dr. Detroit, 48235		11800 12 Mile Rd. Warren, 48093	
Mary Appelt, MD	AN/GS	Thomas R. Doerr, MD	PS
425 Cherry St., S.E. Grand Rapids, 49503		3537 E. Front St. Traverse City, 49684	
Henry B. Ancheta, MD	GP	Steven A. Dosh, MD	IM/FP
4059 W. Davison Detroit, 48238		128 Michigan Ave. Gladstone, 49837	
Delores F. Baker, MD	OBG	Abner J. Espinosa, MD	IM/RHU
4727 St. Antoine Detroit, 48201		4484 First St. Columbiaville, 48421	
Albert H. Capanna, MD	NS	Marcelo B. Espiritu, MD	OTO
20811 Kelly Rd., L-10 East Detroit, 48021		19501 E. Eight Mile Rd. St. Clair Shores, 48080	
Wayne M. Couwenhoven, MD	IM/PUD	Bruce W. Evans, MD	AN
1001 Medical Park Dr., SE #211 Grand Rapids, 49506		18415 Saxon Birmingham, 48009	
Mark E. Cowen, MD	IM	Paul O. Farr, MD	GE/IM
3075 Clark Rd. #103 Ypsilanti, 48197		200 Jefferson, SE #778 Grand Rapids, 49503	

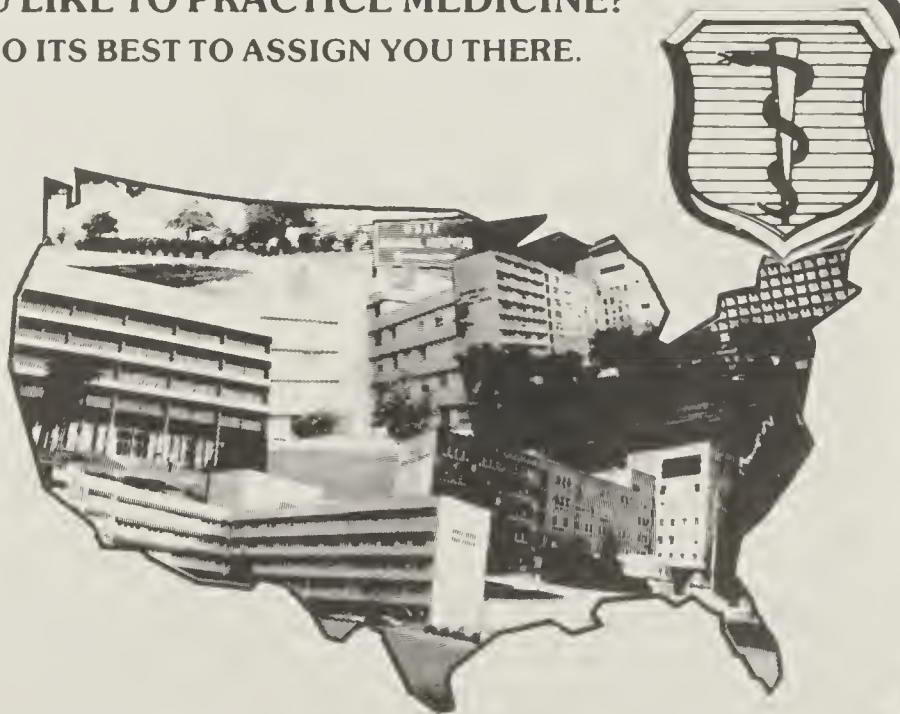
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New AHA publication guide to physician recruitment

Physician Recruitment and the Hospital, by Harry E. Olson, Jr., PhD, contains practical information on how to set up a physician recruitment program, with special emphasis on the needs of the small or rural community. The roles of the administration, the board, the medical staff, the recruitment committee, and the community itself are discussed.

Published by the American Hospital Association, this book provides step-by-step guidelines for physician recruitment, from assessing the needs of the community to locating poten-

tial candidates to retaining the recruited physician.

This book should be of particular interest to hospital administrators, board members, physicians, and community leaders, and others who are concerned with maintaining and improving high-quality medical care in their area.

Physician Recruitment and the Hospital, AHA catalog no. 1035, is available for \$12 to members and \$15 to nonmembers from the American Hospital Association, P.O. Box 96003, Chicago, 60690.

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DEATHS

C. Douglas Dawe, MD Lansing

C. Douglas Dawe, MD, Lansing, died Sept. 10 at the age of 59. Doctor Dawe was chief of Ingham Medical Hospital's gynecological staff since 1961, and served as vice chairman of the medical staff from 1962 to 1964. He earned his MD from the University of Michigan Medical School in 1950 and began his practice in 1954.

Philip M. Henderson, MD Albion

Philip M. Henderson, MD, Albion, died Sept. 18. He was 77. Doctor Henderson received his MD from the University of Michigan Medical School in 1929. He was appointed Albion City health officer in 1947, assistant health officer in 1949, and assistant chief of the medical division of the Albion Civil Defense Department in 1950.

Pearl Kendrick, PhD Grand Rapids

Pearl Kendrick, PhD, Grand Rapids, died Oct. 8 at the age of 90. Doctor Kendrick's research with Grand Rapids school children in the 1930s led to the development of whooping cough vaccine. She received her doctorate in microbiology from Johns Hopkins University and moved to Lansing in 1920 to work as bacteriologist for the Michigan Department of Health's Bureau of Laboratories. Doctor Kendrick was a life member of the Michigan Public Health Association, the Michigan Academy of Science and served as president of the American Public Health Association in 1943.

Paul R. Lieberthal, MD Ironwood

Paul R. Lieberthal, MD, Ironwood, died Oct. 9. He was 85. Doctor Lieberthal earned his MD from Northwestern University in 1923. He was a past president of the Gogebic County Medical Society and had maintained a practice in Ironwood since 1925.

Michael S. Rowda, MD Lincoln

Michael S. Rowda, MD, Lincoln, died Sept. 24 at the age of 67. Doctor Rowda earned his MD from the University of Michigan Medical School in 1937. He was affiliated with Providence Hospital until his retirement in 1978 and served as chief of surgery in 1969 and 1970. Doctor Rowda was a member of the Detroit Medical Society and the Abdominal Surgical Society.

John F. Wurz, Jr., MD Grand Rapids

John F. Wurz, Jr., MD, Grand Rapids, died Oct. 5. He was 67. Doctor Wurz earned his MD from the University of Michigan Medical School in 1937. At the time of his death, Doctor Wurz was affiliated with St. Mary's Hospital. He had maintained a private practice in Grand Rapids since 1940.

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C. Sales to dealers, number none.

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Election results provide physicians with opportunity and responsibility

By John R. Ylvisaker, MD, MSMS President

I am interrupting my series of essays on reimbursement and regulation issues to comment on the significance of the election results for medicine and for the physicians of Michigan.

The Setting

As many, if not most, of us view the status of "government," we recognize that its constant growth and total size have made it seemingly unmanageable and even uncontrollable. Years of legislative initiatives have extended the authority and involvement of government well beyond the commonly-accepted three basic functions of government: national and civil defense, protection of life and property, and adjudication of claims or settlement of disputes.

Many claim that government has exceeded constitutional authority in matters of taxation, property rights, and individual freedom.

By a combination of citizen/constituency demand and legislator response, an administrative bureaucracy has been created which has all but taken the process and substance of governing out of the hands of those elected to govern. Ex-President Ford, commenting publicly on the issue, wrote: "Congress has really lost its capability to respond," and "The President has lost the ability to maintain control of the federal bureaucracy."

We have grown accustomed to seeing our legislators stand helpless and ineffective against the excesses of government; the burgeoning of the budget and the national debt, the regulatory in-

vasion of private lives and business, the domination over state government by manipulation of tax dollars, and the undermining of individual responsibility by transfer payments and the fostering of dependence on government.

The Change

Suddenly, we have been treated to what appears to be a resurgence of the voice and will of the people: "We've had enough; we want a change!" This unexpected exercise of voting power seen in the election results makes the most cynical of us wonder if those elected to govern may now have been given the mandate to take control back from the bureaucracy.

The Opportunity

The broad significance of this for all citizens is that national priorities can now be re-ordered, existing excesses of regulation may be controlled, and a large element of individual responsibility can be restored IF our president and legislators respect and follow the mandate for limited, controlled government.

The significance for medicine and for physicians is that the change in political venue creates a receptive and open environment for re-application of those principles of free enterprise which have made American medical care the best in the world.

Legislators now will be given the courage to challenge the bureaucracy on regulatory issues, to pursue regulatory reform, to dismantle unworkable or ineffective programs. Any and all na-

tional health issues will be open to reevaluation on the basis of free competition, individual responsibility, and a return to limited government.

On the state level as well, there will be an opportunity to challenge the ever-increasing regulatory mode of the legislature and the inordinate rule-making authority of administrative departments and agencies.

The Responsibility

But all of the above will be but a passing fancy if physicians fail to follow through with responsible participation and involvement:

1. We must mobilize the troublesomely silent majority of our colleagues who do not involve themselves in the support or process of organized medicine's efforts to achieve the best possible environment for the teaching and practice of medicine.

2. We must develop and support knowledgeable leaders to engage the issues.

3. We must avoid self-serving demands and expectations which deprive others of the rights we insist on for ourselves.

4. We must "lean on our legislators" consistently, firmly, with knowledgeable advice and direction, with positive alternatives or initiatives and with active support or rational disapproval.

We physicians must accept our individual and collective responsibility as part of the new mandate we have helped effect.



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Warnings: Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia with purpura in elderly patients on certain diuretics, primarily thiazides. Sore throat, fever, pallor, purpura or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended; therapy should be discontinued if a significantly reduced count of any formed blood element is noted.

Precautions: Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function.

Adverse Reactions: All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. **Blood dyscrasias:** Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. **Allergic reactions:** Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. **Gastrointestinal reactions:** Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea and pancreatitis. **CNS reactions:** Headache,

peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. **Miscellaneous reactions:** Drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L. E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.

Dosage: Not recommended for infants less than two months of age.

Urinary Tract Infections: Usual adult dosage—1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 10-14 days.

Recommended dosage for children—8 mg/kg trimethoprim and 40 mg/kg sulfamethoxazole per 24 hours, in two divided doses for 10 days. A guide follows:

Children two months of age or older.

Weight		Dose—every 12 hours	
lbs	kgs	Teaspoonfuls	Tablets
20	9	1 teasp. (5 ml)	½ tablet
40	18	2 teasp. (10 ml)	1 tablet
60	27	3 teasp. (15 ml)	1½ tablets
80	36	4 teasp. (20 ml)	2 tablets or 1 DS tablet

For patients with renal impairment:

Creatinine Clearance (ml/min)	Recommended Dosage Regimen
Above 30	Usual standard regimen
15-30	½ the usual regimen
Below 15	Use not recommended

***Pneumocystis carinii* pneumonitis:** Recommended dosage: 20 mg/kg trimethoprim and 100 mg/kg sulfamethoxazole per 24 hours in equal doses every 6 hours for 14 days. See complete product information for suggested children's dosage table.

Supplied: Double Strength (DS) tablets, each containing 160 mg trimethoprim and 800 mg sulfamethoxazole, bottles of 100; Tel-E-Dose® packages of 100. Tablets, each containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 40, available singly and in trays of 10. Oral suspension, containing in each teaspoonful (5 ml) the equivalent of 40 mg trimethoprim and 200 mg sulfamethoxazole, fruit-licorice flavored—bottles of 16 oz (1 pint).



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Her next attack of cystitis may require
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Bactrim has shown high clinical effectiveness in recurrent cystitis as a result of its wide spectrum and distinctive antimicrobial action in the urinary, vaginal and lower intestinal tracts.

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Bactrim diffuses into vaginal fluid in effective concentrations, thus combating migration of pathogens into the urethra.

Studies have shown that Bactrim acts against *Enterobacteriaceae* in the bowel without the emergence of resistant organisms. Thus, Bactrim reduces the risk of introital colonization by fecal uropathogens. It has *no* significant effect on other normal, necessary intestinal flora.

**Bactrim fights uropathogens in the
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MEDIGRAM

CAPSULES

THE NEW BLUE CROSS Blue Shield of Michigan reform bill (HB 4555), now on the Governor's desk for signing, requires BCBSM to seek input in the development of cost containment plans for each provider class. MSMS will form a work team to provide such consultation and advice as may be required under the new statute. Names of the work team will be announced later.

EFFECTIVE DEC. 1, the Disability Determination Service of Michigan may pay up to \$13 for reports of record from physicians relative to applicants for disability benefits. This change is due to the Social Security Disability Amendments of 1980, according to Harry D. Nesmith, MD, chief medical consultant, DDSM. Previously, the Service could reimburse only for the Title XVI (SSI) cases. It now can pay for both Title XVI and Title II. There must be a bill submitted by the physician to enable the Service to pay.

THE MICHIGAN DEPARTMENT of Mental Health is revising guidelines and informational materials on Hepatitis B, for use by providers of care to the developmentally disabled. Interested physicians may contact Eric Goldstein, PharmD, Director, Office of Health Services, Lewis Cass Building, Lansing, 48926.

Michigan delegation to the AMA gets action on two resolutions

Michigan's delegation to the AMA House of Delegates Interim Meeting Dec. 7-10 played a key role in forging a strong, new position on health planning legislation. Hopeful that the Reagan administration and Congress will join with organized medicine in condemning the encumbrances of PL 93-641 (the National Health Planning and Resources Development Act), four AMA resolutions and a board of trustees report called for repeal of the act. At the same time, delegates voted for local planning of medical services and resources. A Michigan resolution had called for increased AMA legislative activity to repeal the bill, with simultaneous AMA action to develop voluntary, "grass roots" planning activities. Hung up on the degree of thrust toward local planning, the House of Delegates finally adopted a substitute resolution combining all four resolutions with a Michigan proposal that AMA immediately develop "principles" for an effective local health planning network. The delegates charged physicians with the responsibility of assuming leadership "wherever state and regional attitudes and directives pose specific problems in regard to planning." . . . Another resolution by Michigan's delegation designed to strengthen and continue the AMA jail health program was referred to the board of trustees for action, while a third Michigan resolution seeking a continuing AMA compilation of legal responsibilities attendant to medical practice was turned down. The delegation acted to seek further information in support of the latter resolution, then perhaps reintroduce it in 1981. . . . Richard J. McMurray, MD, Flint, chaired the Michigan delegation, while Robert D. Allaben, MD, Detroit, served on Reference Committee D of the House of Delegates, dealing with matters affecting hospitals and medical facilities. . . . At the opening session of the Interim Meeting, Lt. Cmdr. Robert E. Rice, Jr., accepted the Benjamin Rush Award for Medical and Community Service in behalf of his father, the late Robert E. Rice, MD, Greenville, who was awarded the honor posthumously. Lt. Cmdr. Rice flew into San Francisco from his home in Seattle after his mother was unable, due to weather, to fly from Michigan.

MSMS HONORED retiring State Rep. Ray Kehres Dec. 16 for his joint efforts with the medical society on Medicaid budgets and programs. MSMS hosted a dinner in Lansing for Mr. Kehres, attended by MSMS Medicaid Liaison Committee members and other MSMS leaders. Mr. Kehres has been chairman for more than 10 years of the House Appropriations Subcommittee on Social Services. "As such," says Immediate Past Medicaid Liaison Committee Chairman David Siegel, MD, "he has joined with us often to devise programs of encouragement to physicians to accept Medicaid patients."

MSMS IS CO-SPONSOR of a major conference on impaired professionals planned March 14-15 at the Hilton Inn North in Worthington, Ohio. Eight groups, including the state medical associations of Ohio, Indiana and Kentucky are co-sponsors of the Mid-Eastern Regional event. The Saturday-Sunday meeting will include presentations on professional stress, prevention of suicide, problems of the "workaholic," early identification of problems, intervention, rehabilitation and re-entry. Please contact Marce Ireland at MSMS headquarters (517/337-1351).

Michigan's Congressman Stockman appointed federal budget director

MSMS is watching with interest as Michigan Congressman David Stockman moves into new duties as director of the U.S. Office of Management and Budget. Mr. Stockman was named early in December to the cabinet post by President-Elect Ronald Reagan. The Republican representative from St. Joseph will take the post when the new administration officially begins business in January. MSMS has had a close working relationship with Mr. Stockman since he first ran for Congress four years ago. The Michigan Doctors Political Action Committee has contributed regularly to his political campaigns and MSMS leaders and staff have met with him several times in recent years.

CHPC-SEM at work again on bed reduction plan

The Comprehensive Health Planning Council of Southeast Michigan (CHPC-SEM) has begun meetings to prepare its second hospital bed reduction plan. CHPC-SEM has to complete this task within 210 days from date of passage of the 1981 criteria and guidelines for bed reductions (Dec. 3). This means the funded plan must be ready in early July, 1981.

The first hospital bed reduction plan completed by CHPC-SEM was voided by the legislature when several factions objected to perceived biases. The legislature then formed a special committee to study CHPC-SEM's bed reduction planning process. The committee made several recommendations. With these recommendations, CHPC-SEM is now beginning the task of re-writing a plan to eliminate approximately 2,400 hospital beds in greater Detroit.

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